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**OCCUPATIONAL THERAPISTS:
THEIR LIVED EXPERIENCE OF
THE PHENOMENON OF EFFECTIVE
OCCUPATIONAL THERAPY WITH
CHILDREN AND YOUNG PEOPLE**

M P Quinn

DOccTher
September 2016

Volume 1 of 2

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THEIR LIVED EXPERIENCE OF
THE PHENOMENON OF EFFECTIVE
OCCUPATIONAL THERAPY WITH
CHILDREN AND YOUNG PEOPLE**

M P Quinn

A thesis submitted in partial fulfilment of the
requirements of the University of Northumbria at
Newcastle for the degree of Professional Doctorate

Research undertaken in Health & Life Sciences: Health
& Wellbeing

September 2016

Dedication

To my beloved Joanna Avantaggiato-Quinn

In recognition of all your kindness

My sincere thanks

Abstract

Occupational therapists: Their lived experience of the phenomenon of effective occupational therapy with children and young people.

Despite regulatory requirements for occupational therapists (OTs) to appraise the effectiveness of their service, there is little empirical evidence to suggest that they do so. This relativist research addresses the need to understand the phenomenon of effective occupational therapy with children and young people (CYP) with complex mental health needs/learning disabilities, in the lived experience of OTs.

Assuming an interpretivist epistemological perspective, a Heideggerian (1962) interpretive phenomenological methodology guided a reflexive relational approach (Finlay and Evans, 2009) to in-depth interviews carried out with eight OTs working in specialist CYP services. Using threefold analytical methods: thematic (Van Manen, 1997a), metaphorical (Ricoeur and Thompson, 1981) and Lifeworld (Ashworth, 2003), results were contextualised using an occupational perspective of health (Wilcock and Hocking, 2015).

Effective occupational therapy with young people identified issues of occupational injustice and was child centred. It supported the development of a sense of occupational being through having an authentic relationship and time and space during therapy. Opportunities to improve health through occupational doing were created through micro grading of activity-based interventions. Utilising their expertise in grading the environment enabled OTs to facilitate young people to set and reach personally meaningful goals to become the experts in themselves and develop a sense of self-hood.

Consequently, outcome measurement toolkits were designed to capture patient and clinician reported experience and outcome measures. Such tools may enable occupational therapists to provide assurance that they are addressing issues of effectiveness as part of their statutory and ethical obligations, planned next stages are to pilot their use with clinicians and children. An important contribution of this study is that it supports the necessary bridging of the areas of paediatric, physical OT and MH/LD specialist OT, to enhance effective holistic occupational therapy.

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For our evening 'sherry o'clock', mixed with wisdom, pride and a passion for learning, which trickled down through generations: I thank my much-loved mum, Ursula.

Finally, my wife and soul mate Joanna who has done everything humanly possible to enable me to focus and thrive through this experience, I am truly grateful.

Author's Declaration

Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this thesis has been approved. Approval has been sought and granted by the Faculty of Health and Life Sciences Research Ethics Review Panel on 1st July 2014.

I declare that the Word Count of this Thesis is 65406 words

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Date: 1 September 2016

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Chapter One: Introduction & Background

Introduction

The focus of this research is on occupational therapy provided to children with mental health and learning disabilities. In particular, it is an investigation into the lived experience of occupational therapists (OTs) (see Appendix 1 for a list of abbreviations used throughout this thesis) of effective occupational therapy (OT). This introduction will provide an overview of the context within which occupational therapy is provided. It will outline the range of presenting problems of children accessing specialist mental health and learning disability services within the NHS in England.

With the notable exceptions of autistic spectrum disorder (ASD) (Marquenie et al., 2011) and Attention Deficit Hyperactivity Disorder (Chu, 2003, Chu and Reynolds, 2007) ; there is limited available evidence of 'effective occupational therapy' with Children & Young People (CYP) with mental health/learning disabilities (MH/LD). What does effective occupational therapy in CYP services (CYPS) look like? This study seeks to understand how occupational therapy meets the needs of children and young people with mental health and learning disabilities. A more detailed explanation of the motivation for researching the effectiveness of such services will be outlined, recognising the multiplicity of definitions and motivations behind the systemic drive for efficacy within the NHS (Department of Health, 2014).

The rationale for the study will be given along with its aim and objectives. Finally, an overview of the research process will be provided including: understanding the literature and context; selecting and implementing a methodology; collating and analysing the data; discussing the findings in

relation to clinical practice and making recommendations for occupational therapy practice.

This chapter will conclude with an outline of the distinctiveness of this study: its focus on the lived experience of OTs working as specialists providing CYPS occupational therapy, underrepresented in the literature. The research will conduct a fundamental, in-depth exploration into the phenomenon of effective occupational therapy with CYP, providing an original and unique contribution to the profession of occupational therapy and the field of child and adolescent mental health/learning disability.

Area of Enquiry

This section will explore the range of mental health conditions which children and young people typically present to statutory services with. It will also discuss the increasing prevalence of children with learning disabilities and the impact this has on lives. The compounding impact of the developmental stages (Berk, 2012) on young people with LD/MH issues, and the difficulties with communicating and understanding the service in which they find themselves, will be outlined. This section will then consider who determines what is provided and needed: is it the child, the family, the multidisciplinary team, the GP or the Commissioner (NHS England and Department of Health, 2015). Finally, the structure of services within which OT is delivered will be explained.

Mental Health Conditions

CYP referred to statutory services present with a range of mental health issues. Within adult mental health services (Parkinson et al., 2012, Lee et al., 2013) there are twenty-one nationally-agreed clusters with associated care packages and pathways, under three main headings of non-psychosis, psychosis and organic conditions. However, CYPS have been unable to agree such a national taxonomy for MH/LD CYP. Typically, specialist CYPS services see children presenting with one or more of the following issues: mental health (anxiety, depression, suicidal, eating disorders); learning disability (autistic spectrum and attention deficit disorders); behavioural issues (challenging behaviour, school refusal, bullying) and emotional Issues (social isolation, abuse, post-traumatic stress disorder).

Whilst some conditions lend themselves to a medicalised diagnostic category, others are formulation-based and multi-faceted, drawing upon psychosocial approaches (Cara and MacRae, 2013) to understanding. Other conditions, such as emerging personality disorder, are actively resisted by practitioners (Reiss and Gannon, 2015) as a medicalised diagnostic label.

As the level of the individual, acuity of the presenting problem (House of Commons, 2016) varies, as does the impact on the lives of the children and the level of concern of those around them. At service and population level, the overall severity of MH problems is reported to have increased greatly (NHS England, 2016c).

Learning Disabilities & Integration

Traditionally, children with mental health problems attended child and adolescent mental health services (CAMHS). The current MH/LD National integration agenda (Joint Commissioning Panel for Mental Health, 2013) seeks a more inclusive approach for children with learning difficulties who are experiencing mental health problems, with commissioned integrated MH/LD services. This has had a significant impact on the type of work which is carried out, the number of referrals received (House of Commons, 2016) and the role of occupational therapy in CYPS specialist services. This briefing report shows an increase in children referred to community CYP Services with autistic spectrum disorder (ASD), attention deficit hyperactivity disorder (ADHD) and global developmental delay, amongst other conditions.

The Integration Agenda: Paediatrics & Mental Health/Learning Disabilities

Alongside the drive for an increased level of integration of mental health and learning disability services, is the improved understanding of the need for integrated physical and MH/LD care. Stemming from the evidence that people with mental health and learning disabilities have a significantly shorter lifespan than those without (NHS England, 2016b), emphasis has been placed upon developing services to have a more integrated concept of physical and MH/LD care, called Parity of Esteem (NHS England, 2013a). Currently the funding and commissioning of these services remain separate but there is a National clinical and policy drive (NHS England, 2016b) to ensure that the physical health needs of CYPS LD/MH patients are met, and conversely the MH/LD needs of children in mainstream, physical services are addressed.

Developmental Stages

Children and young people enter CYPS services across the whole range of developmental stages (Berk, 2012), from birth to eighteen years and within variable centiles against established norms (World Health Organization and United Nations Children's Fund, 2009). Consequently, therapeutic approaches used for the presenting condition/s must be adapted and amended so that it is developmentally appropriate to the child. Often children who have presented with mental health and or learning disabilities have an associated developmental delay as they may not have had the opportunities other children have typically had (Kolehmainen et al., 2011). The application of sensory processing assessment and intervention, is increasingly prevalent (Cohn et al.,

2000, Cohn, 2001), popular with families, though remains a contentious issue in OT practice and academia (Rogers, 2015, Miller et al., 2007, Park, 2005, Polatajko and Cantin, 2010).

Service Delivery Structure

Demand for community and inpatient services for children and young people have increased dramatically (House of Commons, 2016), resulting in impacts on local commissioning and pressure on provider NHS Trusts to deliver services that are both efficient and effective. The concept of effectiveness and its meaning to a range of stakeholders interested in CYP service delivery will be further explored. As a consequence of service integration policy and NHS England (NHSE) commissioning intentions, both community and in-patient services now receive CYP with MH and mild to moderate learning disability.

Community Services

For CYP to access community services, known as Tier 3 services, they will already have been seen by their GP (Tier 1) and primary care targeted services (Tier 2), and require a more specialist level of intervention in order to resolve presenting problems. Typically, such community services are commissioned to provide services close to home, and CYP would attend an outpatient appointment with parents where they would be assessed and then attend specific interventions to address the identified need or be signposted to other services for support (Child Outcomes Research Consortium, 2014, Davies and Lowes, 2006, Edbrooke-Childs et al., 2015, Furber and Segal, 2012, Gardiner

and Brown, 2010, Harrison and Forsyth, 2005). Depending on the service approach, OTs may be involved in this initial assessment or be a sub-speciality within the service providing specialised OT assessment and intervention.

In-Patient Services

Where Tier 3 CYP services have been unable to help resolve presenting problems of the child and family, in-patient, Tier 4 services is the final stage of increasingly intensive therapeutic options. These can be mainstream (NHS England, 2013b) or specialist forensic (NHS Commissioning Board, 2013) services, the latter being where CYP have a criminal record as well as a MH/LD issue, and require secure, or locked, services.

Summary

This section has concentrated on illuminating the needs of the children who access specialist mental health and learning disability services in NHS England. It has outlined the range of mental health / learning disability conditions which children present with and the need for increased integration across services in order to ensure that the holistic needs of young people are correctly addressed. It outlined the challenges which arise from developmental delay, such as impaired understanding or communication problems, which require particular attention in order to empower children to be able to communicate their wishes. This section ended with an outline of service structures within which OT is provided. In contrast, the next section will outline

the power and influence of national legislation, policy and local guidelines which directly shape current service design and provision.

OT Practice Context

This section looks at OT and the notion of effectiveness, as defined by various sources, and the statutory obligations which OTs have in relation to this study. It will go on to outline the absence of both the voice of the child and OTs within the literature. The insider researcher position will be outlined, alongside the motivations behind the research endeavour.

Effectiveness & Occupational Therapy

Occupational therapy is provided to children and young people within community and inpatient multidisciplinary teams which are required to adhere to NHS Trust Policy. NHS organisations in England are independently regulated by the Care Quality Commission and are required to meet standards for safety, effectiveness, responsiveness, caring, and being well-led and:

‘Effective: By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence’.

Care Quality Commission (2016a)

This legal requirement prompts services, managers and clinicians within MDTs to question whether occupational therapy within CYP NHS services is effective.

Occupational therapists are also regulated by (and must be registered with) the Health Care Professions Council (HCPC), as a prerequisite to working in NHS England (Health and Care Professions Council, 2014) and using the legally protected title of Occupational Therapist. As such, they are required to adhere to three HCPC Standards: Proficiency (Health Care Professions

Council, 2013); Conduct, Performance and Ethics (Health Care Professions Council, 2013); and Continuous Professional Development (Health Care Professions Council, 2012). Each of these three standards refers to effectiveness:

‘Registrant occupational therapists must: 1. be able to practise safely and effectively within their scope of practice’

(Health Care Professions Council, 2013, p. 7)

‘What is CPD? We define CPD as ‘a range of learning activities through which health professionals maintain and develop throughout their career to ensure that they retain their capacity to practise safely, effectively and legally within their evolving scope of practice’. (This definition is taken from the Allied Health Professions project, ‘Demonstrating competence through CPD’, 2002.)’

(Health Care Professions Council, 2012, p. 1)

‘When we say someone is ‘fit to practise’, we mean that they have the skills, knowledge, character and health they need to practise their profession safely and effectively.’

(Health Care Professions Council, 2016, p. 11)

These are regulatory body minimum standards, set to protect the public and provide a framework for the quality of practice expected. In addition to these legally required standards, OTs must also meet the quality standards set by their professional body, the College of Occupational Therapists (2011), which provide a benchmark of expected good practice and would be referred to in a court of law.

Standards relating to accountability require that:

‘1.2.1 You practise according to any codes of conduct or standards that relate to your work, as defined by your profession and national regulatory bodies.’

(College of Occupational Therapists, 2011)

Consequently, those who are not endeavouring to practice occupational therapy effectively are in breach of the HCPC and CQC Regulatory statutory requirements and COT Professional Standards. Within this context, the lack of evidence of this undertaking in peer reviewed professional publications within CYP OT is remarkable, as is the absence of a definition of effectiveness by either HCPC or COT.

The College of Occupational Therapists (COT) allude to effectiveness in their statement:

'The purpose of occupational therapy is to enable people to fulfill (SIC), or to work towards fulfilling, their potential as occupational beings. Occupational therapists promote function, quality of life and the realisation of potential in people who are experiencing occupational deprivation, imbalance or alienation. They believe that activity can be an effective medium for remediating dysfunction, facilitating adaptation and recreating identity.'

(College of Occupational Therapists, 2009, p. 1)

Though not explicitly defined, the outcome of effective OT is outlined in relation to patient functional benefit, quality of life, role identity, developing adaptive skills and addressing issues of occupational injustice. This terminology will be further explored in the review of literature to follow and Chapters 9 & 10.

It is both a requirement and a challenge for OTs to gain informed consent from service users and provide information on treatment options and their effectiveness, where there is a lack of evidence to call upon.

'1.3 You must encourage and help service users, where appropriate, to maintain their own health and well-being, and support them so they can make informed decisions.'

(Health Care Professions Council, 2016, p. 5)

In the absence of such information, there is a professional responsibility to investigate the phenomenon of effectiveness, acknowledging the dearth of definitions associated with it, and to begin the process of generating the evidence (Bannigan, 2004, Long and Cronin-Davis, 2006, Unsworth, 2011, Ballinger, 2012, Morley and Smyth, 2013) upon which service users and OTs can make informed choices.

OT and Historical Non-Directive Play Therapy

Historically, occupational therapists have had a key role in the assessment and treatment of children who are experiencing significant emotional trauma as a result of past trauma, such as physical, emotional or sexual abuse and neglect. Outlined in the seminal book *Dibs, in search of Self* (Axline, 1990), occupational therapists such as Telford (Kaplan and Telford, 1998) recognised play as the primary occupation of children and assumed an Axlinian nondirective play therapy (NDPT) approach, often delivered over months and years of weekly sessions. Whilst anecdotal evidence often described NDPT as life-changing (Petruk, 2009) for the children involved (Kaplan and Telford, 1998), differentiating the benefits of such intensive therapy against natural maturation and multifaceted contextual issues made amassing the evidence base of its effectiveness problematic. For this and a multiplicity of factors (Hitch, 2016) unknown in CYPS OT, generating research evidence of effective practice in OT has been a long-standing gap in the literature and the cultural practice of occupational therapy in CYPS.

The Silent Voice of the Child

For the child referred by the GP, the level of understanding of why they are attending CYPS can vary greatly, compounded by their developmental stage (Berk, 2012) and associated communication challenges. Such communication difficulties may stem from physical or emotional issues and can relate to issues of perceived and actual levels of power and control (Taylor et al., 2010). The sociological phenomena of empowering children to have a robust self-esteem (Roberts, 2006) remains a relatively modern concept. Many therapeutic options rely heavily on verbal communication, or talking therapies (NHS England, 2016a), beyond the capability of the child. Consequently, occupational therapy which focuses on activity, occupation and day-to-day doing, often finds children are more able to express themselves through non-verbal methods.

Despite national policy requiring services to collate information about the outcomes and experiences of patients in the NHS ('NHS Outcomes Framework,' 2013), hearing the voice of children and young people through the use of patient reported outcome (PROMs) and experience measures (PREMs), can be very challenging in practice. Their presenting difficulties may include significant cognitive and communication problems, making it unclear of what is being asked of them. It can be challenging for young people to influence the services they are receiving due to: the accessibility, design and method of collating patient feedback mechanisms (Picker Institute Europe, 2015); perceived power differentials between CYP and the professionals seeking feedback; and their own belief systems as to whether it is worthwhile.

Subsequently, without research capturing the voice of the child or those responding on their behalf, there is little to guide the OT to redesign their service provision to be more effective from the CYP perspective. In the absence of research findings of patient-reported outcome or experience measures related to effective OT with CYP to guide practice, the final source is the OTs themselves.

The Silent Voice of Occupational Therapy in CYPS

OTs have been working in CAMHS and CYPS for many years, but the nature of their clinical practice and what makes it more or less effective is absent from the professional literature. However, from HCPC Standards of proficiency (Health Care Professions Council, 2013) and COT Professional standards (College of Occupational Therapists, 2011), the requirement to consider service user feedback and constantly evaluate OT programmes with individuals is a requirement which is firmly embedded in OT practice.

Additionally, HCPC Standards of Continuing Professional Development aim to:

‘ensure that they (registrants) continue to be able to practise safely, effectively, and legally, within their changing scope of practice.’

(Health Care Professions Council, 2012, p. 1)

Having established that the clinical scope of practice for CYPS OTs has changed as a result of legislation, policy and commissioning intentions (to include LD and co-morbid physical conditions and that acuity of conditions is generally greater (House of Commons, 2016), the need to meet CPD standards 3 and 4 in particular is pressing.

- ‘Our standards for CPD say that a registrant must: ...
3. seek to ensure that their CPD has contributed to the quality of their practice and service delivery;
 4. seek to ensure that their CPD benefits the service user...’

(Health Care Professions Council, 2012, p. 2)

In the light of these and previous CPD standards, since 2005 occupational therapists are likely to have sought CYP views of progress, reflected and subsequently amended their practice, endeavouring to improve the quality of the therapy they offer and its benefit to service users.

Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) (NHS England, 2012), enforced by CQC, requires that NHS Trusts supports workers:

‘to enable them to deliver care and treatment to service users safely and to an appropriate standard, including by— (a) receiving appropriate training, professional development, supervision and appraisal.’

(Care Quality Commission, 2010, p. 28)

These requirements for clinical and managerial supervision were further supplemented in 2013, in line with the Winterbourne View review concordat (Care Quality Commission, 2013), to prompt NHS Trusts involved in providing care to people with learning disabilities to have policies on clinical supervision. The well-embedded culture of professional supervision in occupational therapy (College of Occupational Therapists, 2010, Wimpenny et al., 2006) requires OTs to regularly evaluate therapy provision, including the child’s perspective of it. It is possible, therefore, that CYPS occupational therapists themselves could be a useful source of knowledge to better understand the phenomenon of effective occupational therapy with children. Understanding what constitutes effective occupational therapy is of primary concern to the profession

(Bannigan and Birleson, 2007). Despite the regulatory bodies stated importance of effectiveness, there remains a surprising paucity of evidence of it in CYPS OT. In summary, from the perspective of the child, family, OT and wider society, evidence of what constitutes effective occupational therapy is urgently needed.

The Insider Researcher Position

Finlay (2002b) emphasises the importance of clarifying the motivation for research for reflexive insider researchers. Having specialised as a Child and Adolescent Mental Health (CAMHS) Occupational Therapist for the past twenty-three years and carried out Masters level research into the clinical reasoning of CAMHS OT, a personal and professional goal is to improve clinical effectiveness for CYP receiving occupational therapy. Additionally, as a Clinical Director of AHP Services in the NHS, ensuring professional standards of practice are adhered to, or facilitating remedial action when they are not, is a core objective.

Summary

This section has investigated the regulatory requirements of OTs to consider the effectiveness of their practice. It has identified that the voice of both OTs and CYP are absent from the literature regarding this area of enquiry. Finally, the researcher's position as an insider is outlined, with the drive to investigate this field rendered transparent and open to critique, an important component of qualitative research which is investigated in depth in chapter eight.

Overview of Research

The rationale for the study and its particular aim and objectives will be detailed in this section. Stemming from this explanation of the study, its distinctiveness and value will be articulated. The thesis structure through which the research enquiry will unfold follows, alongside a summation of the key points of this introductory chapter.

Rationale

In the absence of other sources of evidence, this study is seeking to understand the meaning of 'effective OT with CYP'. The principal focus of this study is to capture the experience of occupational therapists who have worked in this specialism for many years in order to identify the salient ingredients of effective occupational therapy with children and young people. This study will focus on gathering rich descriptions of effective therapy with children, from the perspective of the occupational therapists working in this specialised field.

Phenomenology offers an valuable opportunity to capture the ambiguity and richness of a phenomenon, prompted by Husserl's call to go 'Back to the things themselves!' in Finlay (2011, p. 3); especially where there appears to be no previous research. It evokes the question of how standardised outcome measures for children have been established, without a more fundamental study of what effective OT with children and young people with MH/LD is – how can we attempt to capture something that has not yet been articulated. Watson (2006) in her World Federation of Occupational Therapists Congress address urged OTs to resist adopting ready-made OT tests and models of practice, in favour of considering applicability and appropriateness, with due

regard for their own and client's cultural identity. In noting that being comes before doing, Watson identified these implications:

- '1. Practice becomes effective when appropriately matched to the cultural beliefs and values of individuals, groups and communities.
2. Service is appropriate when adapted to the needs of particular cultural contexts
3. The profession will have the potential to reinvent itself, within the scope of its core philosophy (e.g. Equalisation of opportunities for marginalised people to become occupationally engaged).'

(Watson, 2006, p. 157)

This research endeavours to capture the nuances of what constitutes effective OT within the particular cultural environment of CYP with MH/LD. The role of OT in CYPS often includes advocating for and speaking on behalf of the children, but it was not feasible to address both silent voices in the literature within the resources available. Given the challenges faced by CYP, it is hoped that an initial phenomenological study illuminating the notion of effectiveness from the OT perspective will lend itself to formulating considered research queries by young people. Any recommendations for further study will consider the child's perspective and endeavour to report findings through suitable communication avenues for CYP.

The research will focus on NHS England only, due to increased legislative variation across the UK (NHS England, 2012) which has directly affected the services commissioned and types of therapy delivered.

Research Title, Aims & Objectives

Title:

Occupational therapists: Their Lived Experience of Effective Occupational Therapy with Children & Young People.

Research Aim:

To explore the phenomenon of 'effective occupational therapy' with children & young people (CYP) with mental health/learning disabilities (MH/LD), through the lived experience of occupational therapists.

Research Objectives:

1. To conduct a qualitative, interpretive phenomenological research study into the phenomenon of 'effective occupational therapy' with CYP with MH/LD.
2. To collect data provided by a range of experienced OTs working in specialist community and in-patients CYP (MH/LD) services in NHS England.
3. To analyse the lived experience data and identify themes and Lifeworld fragments (Ashworth, 2003).
4. To interpret the meaning of the lived experience of 'effective occupational Therapy' within the conceptual framework of the Occupational Perspective of Health (OPH) (Wilcock and Hocking, 2015)
5. To gather metaphors for 'effective occupational Therapy' from participants and offer an interpreted metaphorical explication of the phenomenon.
6. To make an original contribution to the body of knowledge and understanding of 'effective occupational therapy' and make suggestions

for future research and practice, relevant to occupational therapy with CYP with MH/LD.

Value of the Study

The distinctiveness of this study lies in its focus on the lived experience of occupational therapists working as specialists providing CYPS occupational therapy: a voice underrepresented in the literature. The research will conduct a fundamental, in-depth exploration of the meaning of 'effective occupational therapy' with children and young people. As such it will provide an original contribution to the profession of occupational therapy within the field of specialist child and adolescent mental health and learning disability services in England. This focus on service-wide provision of OT, rather than by diagnostic category, also reflects the reality of such provision in England, where OTs focus on occupational need and problems related to disrupted daily lives, rather than on a medicalised view of the CYP. It is perhaps this lack of diagnostic focus that has beleaguered the development of robust research into OT in CYPS, compared to the study of OT in the field of physical paediatrics, exemplified by significant advancements in the role of OT within neurological diagnosis (Kolehmainen et al., 2014), a phenomenon that will be further discussed in the literature review chapter.

The chosen phenomenological approach does not seek a truth which has generalisable attributes, but findings within a specific context and, as such, would necessarily be a modest contribution (Finlay, 2011) which provides insights into a little-known phenomenon. The primary importance of the study is its response to the statutory requirements of regulatory bodies, whose

purpose is to protect the public and ensure therapists consider the effectiveness of their practice and endeavour to improve outcomes, thereby enhancing the quality of life of C&YP by contributing to the development of best available evidence. Finally, the study will offer insights for practice development in this field and for future research.

Outline of Thesis

This thesis will look at the literature surrounding the study of effectiveness in OT and will move on to outline the methodology and methods that will be used to meet the project aims. Data analysis chapters will look at emerging themes, Lifeworld and their analysis, moving on to a synthesis of these findings within the conceptual framework of the Occupational Perspective of Health (Wilcock and Hocking, 2015). Following this the reflexive chapter will provide an analysis of a range of types of reflection (Finlay, 2002a), clarifying the insider researcher position and its influence on the study. The discussion chapter offers visual frameworks summarising the findings and contextualising them into the wider conceptual world of occupational therapy and a metaphorical explication of effective OT with CYP. Implications for OT practice and research are outlined in the recommendations chapter, along with a consideration of how OTs could influence decision makers and assume a wider role within the multi-disciplinary team. In conclusion, this thesis will summarise the research problem, design and multi-layered analysis and move on to place these findings within a wider context.

Summary

This section has provided an overview of the research project: the rationale; aim and objectives; its value; and an outline of the structure of the thesis. The overall synthesis of this chapter will now be provided, pulling together the three sections and their core purpose.

Conclusion

This introductory chapter has contextualised OT in CYPS in NHS England specialist community and in-patient services for children with mental health and learning disabilities. It outlined the importance as well as the challenges of the national integration agenda of parity of esteem (NHS England, 2013a) across MH/LD and physical paediatric care. It outlined the range of presenting problems of children accessing specialist mental health and learning disability services within the NHS in England, and the limited available evidence of 'effective occupational therapy' in this area.

Recognising the silent voice of the child and the occupational therapist in the literature, the regulatory context was detailed, showing a statutory obligation for OTs to look at the effectiveness of their interventions for the well-being of the CYP they serve. The research aim to explore the phenomenon of 'effective occupational therapy' with CYP was identified, underpinned by six research objectives. Having identified this gap in current knowledge and the motivational drives of the insider researcher position, the overall value and uniqueness of the study was outlined. An overview of the thesis indicates the journey through the literature, methodology and analytical components of the argument, which will be synthesised in the discussion and develop subsequent recommendations for research and practice: thereby satisfying an essential aspect of the professional doctoral process.

Chapter Two: Literature Review

Introduction

This narrative literature review (Green et al., 2006) chapter, provides an overview: synthesising previously published information relevant to the research aim. Consequently, a broadly encompassing perspective of this research topic is provided, funnelling a vast array of contextually applicable literature: research, NHS England policy, inter/national definitions, professional guidelines and clinical/service standards that impinge upon OT practice, in specialist child MH/LD. The preliminary search of the literature on effective occupational therapy practice with children, identified insufficient numbers of directly relevant clinical articles to enable a qualitative systematic literature review to be carried out. This enabled the research topic to be refined and identified the scope of this narrative review. A retrospective appraisal of the literature review was undertaken post data analysis, which prompted inclusion of other articles related to the principal findings.

Information was sourced through electronic databases (such as Pubmed, AMED, Cinahl, Cochrane) and national websites for professional, regulatory bodies, NICE and NHS England. Search terms were used to systematically retrieve information, using Boolean operators for inclusive and focussed searches. An Endnote referencing software database was created to theme, store and rate over two thousand articles and sources, with over three hundred of the top rated articles identified and used as essential references throughout the thesis.

Looking firstly at the international conceptualisation of health, section one will explore the World Health Organisation's (1998) stance and the associated

International Classification of Functioning (World Health Organisation, 2001). Within this framework the Occupational Perspective of Health (OPH) (Wilcock and Hocking, 2015) will be outlined, along with the related declarations and statements provided by the World Federation of Occupational Therapists (WFOT) to guide professional practice across the globe.

More locally, section two will explore the legislation within which the NHS in England operates, coupled with key policy drivers affecting mental health and learning disability service providers. It will revisit the drive to include the views of CYP through the requirements for patient-reported outcome and experience measures ('NHS Outcomes Framework,' 2013) encapsulated in the new Five Year Forward View for Mental Health (5YFVMH) (NHS England, 2016b).

Section three focusses on the quality agenda, and how it relates to effectiveness, the variation in definitions of effectiveness and the dominant discourses and commissioning levers which guide clinicians' thinking. Section four extends this evaluation of the meaning of effectiveness and focusses on the field of occupational science and its call for OTs to be ambassadors for occupational justice. Moving towards the field of occupational therapy practice, it also explores the concept of occupational performance (Christiansen et al., 2015), how effectiveness may be construed.

Section five will outline the place of OT models of practice and associated beliefs and values, within this research. It will explore evidence from adult mental health services as to what constitutes effective OT for an older population. Synthesising this conceptual journey into its meaning for

practitioners delivering OT, the final section considers core skills of OT in analysing activity and helping CYP to set goals and outcomes of OT.

Conceptualising Health

This section explores the concept of health from the perspective of the World Health Organisation (WHO) and its International Classification of Functioning. It then explores the Occupational Perspective of Health (OPH) (Wilcock and Hocking, 2015) and the challenges of defining occupation. Drawing upon these two influential perspectives of health, the world Federation of Occupational Therapists (WFOT) declaration of occupational rights will be explored alongside its statement on occupational therapy.

World Health Organisation Definition of Health

The World Health Organisation (WHO) definition of health (World Health Organization, 1948) has remained unchanged for over 60 years:

‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’

(World Health Organization, 1948, p. 100)

The International Classification of Functioning, Disability and Health

The International Classification of Functioning, Disability and Health (ICF) is

‘...known more commonly as ICF, is a classification of health and health-related domains. As the functioning and disability of an individual occurs in a context, ICF also includes a list of environmental factors.

ICF is the WHO framework for measuring health and disability at both individual and population levels. ICF was officially endorsed by all 191 WHO Member States in the Fifty-fourth World Health Assembly on 22 May 2001(resolution WHA 54.21) as the international standard to describe and measure health and disability’.

(World Health Organisation, 2001, p. 1)

The ICF has developed as an online tool for the classification of functioning, which the global community of occupational therapists have considered to lesser and greater extents (Shaw et al., 2007, Haglund et al., 2012, Farrell et al., 2007, Daremo and Haglund, 2008, Bendixen and Kreider, 2011) for its utility in various areas of clinical practice and effectiveness in capturing participatory outcomes following occupational therapy intervention.

Occupational Perspective of Health

The Occupational Perspective of Health (OPH) is a developing framework (Wilcock, 1998, Wilcock, 1999, Wilcock, 2006, Wilcock, 2007, Wilcock and Hocking, 2015) built on the insights gained through a College of Occupational Therapy commission to capture the history of occupation in previous centuries, to present times (Wilcock, 2001, Wilcock, 2002).

Defining Health and Occupation:

Wilcock in her seminal works creating and developing the OPH, originally identified three key areas: occupational doing, occupational being and occupational becoming. Wilcock's more recent edition of the OPH includes the concept of occupational belonging and present a simple formula to convey a complex conceptualisation related to health: 'd+b3=sh', encapsulating the idea that doing plus being, becoming and belonging equate to survival and health (Wilcock and Hocking, 2015).

Occupational Justice & Injustice

Occupational justice (and the role of OT practitioners, educators, managers and researchers) was the focus of further ground-breaking developments within the OPH (Wilcock and Townsend, 2000, Townsend and Wilcock, 2004). Prompting international dialogue about client-centred activism, they posed the question of how OT works for justice and posited four occupational rights.

Outlining the associated injustices, they proposed occupational alienation, deprivation, marginalisation and imbalance as identifiable risks which can be addressed at the level of individuals, populations and societies.

Occupational imbalance is defined as un-occupied, under occupied, over occupied or having an imbalance of meaningful activities. Occupational alienation is defined within the OPH as a sense of disconnectedness and isolation. Occupational deprivation, defined as prolonged preclusion from engagement, outside of the control of the person. Occupational marginalisation has been described as one of the more invisible occupational injustices, as it is often hidden in normative standards which dictate where, when and how people will or should participate.

A critical analysis (Hitch et al., 2014a, Hitch et al., 2014b) of each of the OPH concepts offered provisional definitions to guide the future evolution of the terms and an understanding of their inter-relatedness.

Defining Occupation

Wilcock's conceptualised this as:

‘Occupation encompasses all the things that people do, is part of their being and integral to their becoming whatever they have the potential to become. Occupation has a biological purpose in that it is the mechanism by which people throughout time, have acquired all they need to accomplish in order to be safe and feel good.’

(Wilcock, 2001, p. 10)

Twinley and Addidle (2012) illuminated the dark side of occupation, such as violent acts/activity, and stimulated others (Blank et al., 2016) to report on such activity and put into relief the socially compliant nature of earlier definitions (Townsend, 1997, Yerxa et al., 1989a). Hocking (2009) had also alluded to such occupations requiring serious study by occupational scientists who had largely ignored occupations which were socially unacceptable, such as tagging (illegal street art), urging occupational scientists to report on all types of occupation. Reed et al. (2010) advocate for greater understanding of the lived experience of occupation, to understand the complexity of factors which may enable or constrain a person’s occupation.

Within this range of opinion, the current WFOT definition of occupation remains and will be used in this research:

‘In occupational therapy, occupations refer to the everyday activities that people do as individuals, in families and with communities to occupy time and bring meaning and purpose to life. Occupations include things people need to, want to and are expected to do’

(World Federation of Occupational Therapists, 2006, p. 2)

Defining Occupational Therapy

Creek was commissioned by the College of Occupational Therapists, to develop a definition of occupational therapy and summarised that OT was a complex intervention and supported this position with a 28 page definition (Creek et al., 2005). A five-year review of the use of this definition showed worldwide usage, though occupational scientists (Creek, 2009) and OTs alike have sought to extend and amend the definition to hone it to an ever emerging and changing professional context. Defining occupational therapy has now become so contended that leading researchers have called to progress without a definitive definition (Duncan, 2011) thus accepting its complexity. Hammell (2009) raised further issues with some of the professions 'sacred texts' which appeared to be beyond critique, though which may not fit the emerging occupational science concepts and realities of practice. Including the understanding of occupation and OT models of practice (Whalley Hammell, 2015) which need to respect variance and be relevant across all cultures.

This study will utilise the WFOT definition:

'Occupational therapy is a client centred health profession concerned with promoting health and well being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement.'

(World Federation of Occupational Therapists, 2013, p. 3)

World Federation of Occupational Therapists on Human Rights

Mirroring the UN universal declaration of human rights, the World Federation of Occupational Therapists (2006) position paper on human rights specifically relates to human occupation and participation. Six principles were established

including the right to participate in a range of occupations that enable people to flourish and fulfil their potential and that people have the right to be supported to participate and engage in an occupation; in order to be included and valued as members of their family, community and society. WFOT cite economic, social and physical barriers to access occupations, as being an abuse of such rights. One of the challenges identified in this statement is for occupational therapists to accept:

‘Professional responsibility to identify and address occupational injustices and limit the impact of such injustices experienced by individuals’.

(World Federation of Occupational Therapists, 2006, p. 2)

Stemming from the social justice movement, the concept of occupational justice is deeply embedded within the occupational perspective of health. Occupational injustices have been identified as: occupational imbalance (doing), occupational alienation (being), occupational deprivation (becoming) and occupational marginalisation (belonging) (Wilcock and Hocking, 2015). Clearly OPH concepts are embedded into this WFOT statement, the relationship between OT and occupational science being the focus of a further statement, which includes the following statement of the significant of occupational science to OT, which is relevant and will be used in this research:

‘Occupational science is significant to occupational therapy because...

It underpins effective occupational therapy practice by providing a rich understanding of occupation as both the therapeutic means and ultimate goal of occupational therapy.’

(World Federation of Occupational Therapists, 2012b, p. 1)

Summary

Drawing upon the WHO concept of health (World Health Organisation, 1998) and the ICF (World Health Organisation, 2001), this section explored Wilcock's (2015) Occupational Perspective of Health (OPH) and the challenges of defining occupation and occupational therapy. It outlined the key aspects of the WFOT position statement on human rights (World Federation of Occupational Therapists, 2006) and the importance of occupational science in underpinning effective occupational therapy practice (World Federation of Occupational Therapists, 2012b). This provides the global context within which occupational therapy with CYP with MH/LD, seeks to be effective.

Government Policy Drivers

There are numerous governmental drivers which have to be taken into account by occupational therapists seeking to provide an effective intervention. In an ever-changing landscape of imperatives, the core developments of recent times, including the Five Year Forward View for Mental Health (NHS England, 2016b), are outlined here along with the statutory requirements of NHS England and its outcomes framework (Department of Health, 2014). Embedded within this framework is the concept of reporting on outcome measures by the patient and clinician, which will lead into a discussion about the use of the Children and Young People's Health Services (CYPHS) Data Set (NHS Digital, 2015) and its implications for OT.

NHS England

Since the Health and Social Care Act (NHS England, 2012) the role of NHS commissioners includes supporting the United Nations Rights of the Child (Office of the United Nations High Commissioner for Human Rights 1989) and identifies duties related to patient and public participation. The House of Commons research briefing on CAMHS provides a comprehensive overview of recent Governmental directives in child mental health which recognise the increasing prevalence of mental health issues:

‘...the majority of these beginning in childhood... 75% of adult mental health problems start before the age of 18.’

(House of Commons, 2016, p. 3)

The identified need to develop and invest more in children's services was in stark contrast to Norman Lamb (Minister for Care services in 2014) stating that

only 6% of the MH budget is spent on CYP, despite this awareness of the link between child and adult mental health. The inequity of NHS funding allocation favouring physical health services and the evidence that someone with a long term MH condition has on average a 15-year shorter lifespan, led to legislation for Parity of Esteem. This principle is enshrined in the Health and Social Care Act (NHS England, 2012) and requires that mental health must be given equal weight to physical health. Implementing this principle, Mind and Rethink Mental Illness charities set up an anti-stigma campaign called Time to Change, requiring everyone, including OTs, to consider parity of esteem in relation to their role.

Sir Simon Stevens, CEO of NHE England endorsed the DoH called for

‘...improving access to effective support’

(NHS England and Department of Health, 2015, p. 13)

He acknowledged the need for radical change in the face of increasing demands and inadequate service provision. With an aspiration that by 2020:

‘Increased use of evidence-based treatments with services rigorously focused on outcomes’.

(NHS England and Department of Health, 2015, p. 17)

The link between effectiveness and funding was explicitly stated in Closing the Gap:

‘The most effective services will get the most funding. In the future this could mean that the best services – i.e. those that deliver the most successful outcomes, such as highest recovery rates – get more funding.’

(Social Care, 2014, p. 16)

The publication of the Five Year Forward View for Mental Health (NHS England, 2016b), a comprehensive plan designed to radically improve mental health services in England, called for a strengthening of the workforce:

‘Every person with a mental health problem should be able to say: Services and professionals listen to me and do not make assumptions about me. Those who work with me bring optimism to my care and treatment, so that I in turn can be optimistic that care will be effective.’

(NHS England, 2016b, p. 41)

Recommended outcomes include enabling more children to be able to access good quality mental health care in a timely fashion, which has since been supported by promises of additional investment in mental health services, including expanding specialist service in-patient provision, thereby providing care closer to home. With such a volume of consistent messages about providing more effective services, combined with the Regulatory Body requirements to do so outlined in the introduction, the search for what constitutes effective OT and how this is communicated to CYP and commissioners, is urgently required.

National Outcomes Framework & Data

The recently revised NHS Outcomes Framework (Department of Health, 2014), is central to the NHS England drive for improvements in health care which aims to ensure accountability of the overall performance of the NHS and improved outcomes for patients. Since 2015 the Children and Young People’s Health Services (CYPHS) Data Set (NHS Digital, 2015) requires provider Trusts to submit data about demographics and outputs to enable a national

picture of comparable information to inform commissioning and research supporting evidence-based practice, policy development, patient choice and compliance with the NHS Outcomes Framework (Department of Health, 2014). Referral to treatment times for Allied Health Professions (AHPs) are being captured for the first time at a local and national level, making the work of occupational therapists more visible.

These overarching commissioning requirements are further supplemented by local commissioning for community CYPHS, which uses financially related performance targets to drive quality improvements such as decreasing waiting times. The net result of these NHS drivers is that services are under ever-increasing financial pressure to deliver services in a more efficient and effective way, coupled with rising referral rates as a result of national trends of increasing acuity (House of Commons, 2016). The outputs of healthcare professionals in this specialist service are under local and national scrutiny, seeking to measure the effectiveness of the interventions they offer, within a context of pressurised services. NHS England has acknowledged that specialist CYP's community services in particular are under increased pressure and have invested nationally in eating disorder services, for example, as an area of increasing prevalence of mental health issues.

Encapsulated in the NHS Outcomes drive is the system-wide use of patient-reported outcome (PROMS) and experience measures (PREMS) (Wolpert et al., 2016, Isobel et al., 2016, Julian et al., 2016, Wolpert et al., 2012), to ensure that services are responding to the needs of service users, a clinical issue which will be further discussed in the next section.

Summary

The requirement for OTs to attend to matters of effectiveness in relation to the occupational therapy they provide to children is clear. This is detailed in key policy legislative and drivers such as the Health and Social Care Act (NHS England, 2012); The Five Year Forward View for Mental Health (NHS England, 2016b); The Future in Mind (NHS England and Department of Health, 2015) strategic goals; the Outcomes Framework (Department of Health, 2014) and Regulatory Body requirements (Health Care Professions Council, 2016, Care Quality Commission, 2016a, Care Quality Commission, 2016b, Care Quality Commission, 2016c).

National Drivers for Clinical Quality & Effectiveness

Having established the statutory responsibility for OTs to address effectiveness in their practice, this section will investigate other national drivers which focus on quality and outcomes. Exploring the concept of quality, the discussion will look at who defines quality in healthcare. Standards related to young people's care will be investigated, alongside demand and capacity models looking at effectiveness across specialist community provision.

Who Defines Quality?

Following investigations into failings within the NHS there have been numerous initiatives to drive up the quality of service provided. Failings at Mid-Staffordshire NHS Trust resulted in two reports by Robert Francis (House of Commons Library, 2013) on the need for improved levels of care and

compassion and to embed the right values and attitudes in order to deliver safe high-quality care. Alongside this clarity of professional accountability and responsibility, occupational therapists, like nurses, are required to be reflective practitioners and endeavour to improve the services they provide. Clearly this has an impact on the clinical reasoning of occupational therapists and their responsibility to ensure that the quality of the services they are providing meets the required standards (College of Occupational Therapists, 2011, Health Care Professions Council, 2016, Health Care Professions Council, 2012, Health Care Professions Council, 2013)

NICE and Evidence-Based Practice

Additionally, commissioned services are required to provide evidence-based practice and adhere to NICE guidance. This poses a real challenge for occupational therapists and other professions where there is a lack of evidence, and the positivistic emphasis of evidence supported by NICE (National Institute for Health and Care Excellence, 2016) may overlook the added value of professions which use a qualitative approach in their effectiveness research (Wimpenny et al., 2014). This is an issue being addressed for occupational therapists in the UK (Jackson, 2015) where a historical lack of investment in research nationally, the lack of career pathways within research and an emergent research profession has resulted in a paucity of substantial evidence-based practice across specialisms such as CYP mental health services. Consequently, NICE Standards related to MH/LD which are often supported by commissioning intentions in the NHS are predominantly medically- and psychologically-based, these professions

having an established academic level which supports the generation of evidence and which attracts funding streams to do so. Hence the philosophies of dominant professional discourses increasingly determine the types of services commissioned.

Foundation Trust Requirements

NHS Foundation Trusts, as financially independent providers of NHS services, can tender for specialist services which have prerequisites in terms of the service specification which must be provided. Having won such a tender, the Trust then has to decide how best to provide the service with financial acumen and ethical consideration of the quality of service provided. Such services will operate with Trust policies and practice guidance directives which can vary across the NHS. Standards for business in the NHS have been established and the overall provision is monitored by CQC as the regulatory authority (Care Quality Commission, 2016a), which considers effectiveness as one of five key lines of enquiry during the inspection process.

QNIC & QNCC

In addition to commissioners performance targets and standards set by NICE and provider Trusts, there are also national standards for CYPS inpatient services and community services. Consequently, these services are highly scrutinised and performance managed for compliance to a range of standards. Mechanisms to measure effectiveness are focussed at team or ward-level outputs and fail to provide the sort granularity of understanding of specific

therapeutic approaches and interventions (NHS Digital, 2015). This has a significant impact for occupational therapists in CYP where evaluative information may have little or no value to clinicians seeking to improve their individual practice. How is effectiveness defined and measured at the level of the individual clinicians practice?

In-patient Commissioning and Quality

In-patient CYPs provision (Tier 4) is centrally overseen by national specialist commissioners through NHS England and is separated into mainstream (NHS England, 2013b) and forensic services (NHS Commissioning Board, 2013).

Future in Mind (NHS England and Department of Health, 2015) identified that transitions around the age of 18 are often unhelpful and children services should be up to the age of 25, thereby straddling difficult maturation issues in the latter teenage years.

Quality Network for Inpatient CAMHS (QNIC)

Since 2001 the Quality Network for Inpatient CAMHS (QNIC) (Royal College of Psychiatrists, 2015) has endeavoured to improve the quality of care through self/peer audit against regularly revised standards and facilitating support and networking for disparate in-patient units across the UK. QNIC standards cross-reference with other required standards, such as CQC, and cover all aspects of the inpatient experience, including: Environment and Facilities; Staffing and Training; Access, Admission and Discharge; Care and Treatment; Information, Consent and Confidentiality; Young People's Rights and Safeguarding

Children and Clinical Governance. Review of key stakeholders provides no evidence of OTs being involved in the setting of these standards though they work in such services and are part of the unit's self-assessment, as well as going out to peer review other units against the established standards. QNIC standards for OT staffing levels recommend 0.5wte for 12 beds, but environmental standards make no specific recommendations for occupational therapy space (such as play rooms, therapeutic kitchen, OT activity room). They do, however, stipulate seclusion, education, indoor and outdoor recreation, dining, interview rooms and de-escalation space.

Community Services Commissioning and Quality

Unlike the national centralised contracting of highly specialist services, commissioning of community CYPS services (Tier 3) is carried out locally through care commissioning groups (CCG). Provision is through community based multi-disciplinary mental health teams helping CYP with complex difficulties.

Quality Network for Community CAMHS (QNCC)

Established in 2006, the Quality Network for Community CAMHS (QNCC) (Royal College of Psychiatrists, 2016), which mirrors the QNIC quality improvement methodology, aims to enhance quality in targeted (Tier 2), specialist (Tier 3), LD and crisis services. The tiered approach is designed for Tier 3 to scaffold the work of Tier 2. As such, occupational therapists contribute to the public health benefits of early intervention and making every contact

count (Public Health England, 2015), thereby developing healthy communities and a philosophy of self-management. In terms of effectiveness, QNCC advocate the routine use of outcome measures to monitor clinical outcomes (Royal College of Psychiatrists, 2016). A more in-depth discussion clarifying the use of outcome measures follows in the final section of this chapter.

CQC and Child Outcomes Research Consortium (CORC)

These measures are also suggested by CQC and the Child Outcomes Research Consortium (CORC) (Child Outcomes Research Consortium, 2014, Isobel et al., 2016).

CORC's **vision** is:

‘for all children and young people’s wellbeing support to be informed by real-world evidence so that every child thrives. Our **mission** is to promote the meaningful use of evidence to enable more effective child-centred support, services and systems to improve children and young people’s mental health and wellbeing....

The CORC approach supports practice in the following areas: Effective interventions with individual clients and families...

Our **mission** is to promote the meaningful use of evidence to enable more effective child-centred support, services and systems to improve children and young people’s mental health and wellbeing.

The CORC approach supports practice in the following areas:

Effective interventions with individual clients and families’

(Child Outcomes Research Consortium, 2014, p. 2)

CORC critiques of the use of outcome measures (Edbrooke-Childs et al., 2015), identifies idiographic patient reported outcomes as more clinically useful than standardised measures in CYPs and the utility of using goal attainment to capture areas (such as confidence and resilience) which may

otherwise be missed by normed outcome measures (Jacob et al., 2016) along with the importance of ensuring the child's voice is heard and included in the goal setting process.

Choice and partnership approach (CAPA)

In addition to QNCC, children services in NHSE have developed an outcomes-focussed model of service delivery called the choice and partnership approach (CAPA)

‘CAPA is a service transformation model that combines collaborative and participatory practice with service users to enhance effectiveness, leadership, skills modelling and demand and capacity management.’

(Choice and Partnership Approach, 2016, p. 1)

CAPA has had widespread uptake in England and around the world, with international collaborations to refine and develop the implementation of the model. The Mental Health Foundation (York and Kingsbury, 2009) evaluation of its use found that support to implement the model was an important aspect of its value within services. A collaborative evaluation (Robotham et al., 2009, Robotham et al., 2010), between the Mental Health Foundation and the Kings Fund, found supportive leadership to be central to the implementation of CAPA, as it helped avoid the overworking of staff in teams which misunderstood its purpose.

Summary

This section has explored the concept of quality and the national benchmarking function in CYP services of: NICE (National Institute for Health

and Care Excellence, 2016), QNIC (Royal College of Psychiatrists, 2015), QCmty (Royal College of Psychiatrists, 2016) and CAPA (Choice and Partnership Approach, 2016). Outlining the quality and outcomes issues in CYPS highlights a complex discourse on enhancing effectiveness in national policy and standard settings, with little conceptual synthesis in terms of defining terms which have become part of the vernacular.

Occupational Science and Effectiveness

Over the past 30 years, occupational science has emerged as the underpinning scientific discipline (Yerxa et al., 1989b, Yerxa et al., 1989a, Christiansen et al., 1996) to occupational therapy (World Federation of Occupational Therapists, 2012b). This section seeks to clarify how occupation is understood and explores the concepts behind the Occupational Perspective of Health. Occupational justice and the associated occupational risks (2015, Townsend and Wilcock, 2004) are explained. The overarching concepts of the OPH are used to aid understanding of what effectiveness means within the field of occupation.

Emerging issues from occupational science proffer a new transactional conceptualisation of occupation, with potential consequences in practice. Concepts of time and occupation are provided, in the context of children's perceptions and experience of it. Finally, separating the study of occupational performance as distinct from the study of occupation (Hocking, 2009), will identify issues for CYPs OT in search of effectiveness.

Practice Implications of Occupational Science

Systematic review of occupational science (Glover, 2009, Frank, 2012, Pierce et al., 2010) and the OPH (Hitch et al., 2014a, Hitch et al., 2014b) indicate that they have contributed to a growing body of knowledge about occupation and at its most esoteric, an expression of moral philosophy with thinking about global human rights at its heart.

Ensuring that occupation is central to undergraduate curricula (Whiteford and Wilcock, 2001) and defining an occupational perspective as 'a way of looking

at or thinking about human doing' (Njelesani et al., 2014, p. 233) is indicative of a future where occupational science and occupational therapy practice are resonant with each other. Questions have emerged as to whether occupational science is too individualistic and too qualitative. Nevertheless, conceptual understandings of occupational balance (Håkansson et al., 2006) have progressed to the exploration of clarifying definitions (e.g. various occupational patterns/areas or roles, responsibilities and performance) and selecting the most appropriate instrument to measure it in practice (Dur et al., 2015).

Re-examination of how occupation and models are conceptualised are stretching OT practice from the individual to community development roles (Leclair, 2010) and challenging long-held concepts which no longer fit the emerging body of knowledge. Challenging the current taxonomies of occupation (self-care, productivity and leisure), the importance of the meaning of occupation is flagged with a starting point offered of 'the call, Being-with and possibilities' (Reed et al., 2011, p. 307).

New evidence-based OT theories are called for which incorporate such emerging new ideas as well as cultural sensitivity and humility: endeavouring to counter 'Professional Eurocentrism, ethnocentrism and intellectual colonialism' (Hammell, 2013, p. 230).

Complexity Theory & Transactionalism

It is generally agreed that the concept of occupation is in itself complex with some occupational scientists seeking to understand it through the lens of

complexity theory. Whitford and Wright St Clair (2005), for example, encourage the application of complexity theory to illustrate the overlap with complex clinical reasoning within a complex system. Dickie et al. (2006) and (Aldrich, 2008) offered a persuasively reasoned alternative to the dualistic notion of separating person, environment and occupation (as exemplified in the widely held PEO model). They postulate that the application of Dewey's theory of transactionalism offers a more holistic concept of occupation as a mode through which people function, which is central to understanding person-context relationships. Whilst straying beyond the aims of this project, this analysis, along with the re-categorisation of occupation by Jonsson (2008), are included as examples of indicative changes in direction in occupational science, which are likely to directly impact upon occupational therapy practice. The questioning of widely-held constructs: person environment occupation; or self-care, productivity and leisure; will impact CYPs OT services, where these model underpin the practice of some therapists and potentially OT models of service delivery.

Time and Occupation

The idea that occupation and time are inextricably connected is well reported within the history of occupational therapy (Farnworth, 2003, Larson, 2004, Kielhofner and Forsyth, 1997) and embedded in the definition of occupation:

'synthesis of doing, being and becoming that is central to everyday life of every person and that provides longitudinal organisation of time and effort'

(Creek, 2003, p. 32)

Tempo, or the pace of life, (Farnworth, 2003) is associated with the body's natural rhythms and damaging health consequences have been put down to disruption in such cycles (Wilcock, 1998). Kielhofner and Forsyth (1997) described temporal patterns in terms of habituation in the Model of Human Occupation and stressed the importance of establishing patterns in daily occupations.

Elkind (2007) first introduced the idea of the hurried child in the 1970s in America. He postulated that within families, schools, the mass media and the workplace, children are expected to grow up fast, resulting in increased levels of stress, which, in turn creates a detrimental effect on children who are unable to enjoy worry-free time experienced by previous, more hopeful and protected generations. This concept is strongly contested by Lynott and Logue (1993) as unrealistic and mythical, mainly due to a lack of evidence to support his claims. However, the notion that the tempo of life has increased in industrialised nations is generally accepted, with occupational scientists (Clark, 1997) calling for attention to not only describing the activities we carry out but to consider aspects of tempo and meaning as well.

Several models of practice relating to 'time and occupation' which synthesise research and theory in this field have been put forward, aiming to enable occupational scientists to research the phenomenon and OTs to improve the design of their interventions. Larson (2004) offered the Dynamic Occupation in Time (DOiT) model which considered the overall occupational context of how variations in perceptions of temporality (time going fast or slow) during an occupation could be better understood (in terms of skills and task complexity) to enable a greater synchronicity between clock time and perceived time.

Perceptions of time were considered within this study and are further discussed in chapters five, six and nine.

Occupational Performance & Occupational Well-being

Occupational scientists have urged researchers to clarify when reporting on studies related to occupation (Hocking, 2009), the difference between the occupation itself and the experience of doing it is often referred to as occupational performance. This study of OT practice with young people is principally concerned with occupational performance, though an analysis of a specific occupation was undertaken and is reported in chapter seven.

Doble and Santha (2008) traced the link between occupational performance and occupational well-being. Calling upon the international classification of functioning (World Health Organisation, 2001) they identified the importance of the concept of participation in life skills and situations, to the profession of occupational therapy. Occupational well-being arises where choice and engagement in occupations and orchestration of occupational lives, enables occupational needs to be consistently met. Seven discrete occupational needs were identified (Doble and Santha, 2008): accomplishment, affirmation, agency, coherence, companionship, pleasure, renewal. They proposed that such subjective experience is an important component of occupational therapy outcomes, describing occupational well-being as the cumulative effect of meaning and satisfaction derived from occupational lives. How subjective meaning is generated has been the source of much debate (Whalley Hammell, 2004) and the need to identify the process by which it happens.

Debating the wider role of occupational therapy and well-being, Hammell and Iwama (2012) urge OTs to consider the profession's philosophical commitment to occupational rights (World Federation of Occupational Therapists, 2006) and human well-being, by not only attending to individual's ability, but also the inequitable conditions which may impede their right to participate in life. Meanwhile, Ziviani and Rodger (2006) emphasise the importance of doing, being and becoming for children with physical disabilities, with the concept of belonging a relatively unreported strand of occupation and health with children.

Summary

This section explored the occupational perspective of health (Wilcock, 2015), occupational justice and risks, and how these may influence effective occupational therapy in CYPS. Exploring the emerging issues from occupational science, perceptions of time and the concepts of occupational performance, the links with well-being provide a valuable context of understanding, within which this research study fits.

Occupational Therapy Practice and Effectiveness

Having set out the wider issues of whether CYP services are effective, the contextual framework within which occupational therapy operates will be provided. Exploring the role of OT, concepts related to occupational science and occupational participation for children will be outlined. How do occupational therapists assess and formulate their intervention from a range of models of practice, and how is their clinical reasoning influenced by the drive to provide the most effective occupational therapy possible within the resources available?

Alongside the national statutory requirements and the range of quality improvement initiatives impacting on CYP services, defining effectiveness for OT requires consideration of a multiplicity of factors. These include professional standards, models of practice and an understanding of the philosophical roots of the profession which influence the beliefs and values of OTs. These factors will be considered here and contrasted with OT practice in adult mental health and child physical health to gain an understanding of how concepts of effectiveness have been understood in these closely-related areas of clinical practice. This section will conclude with a synthesis of the key considerations for OTs in practice and the challenge of capturing effectiveness as a phenomenon, as part of this study.

Defining Effectiveness for Occupational Therapy

The College of Occupational Therapists set the Occupational Therapy Standards of Practice (College of Occupational Therapists, 2011) and highlighted the need for effectiveness in practice and process:

‘4.5 You evaluate the impact of, or your service users’ responses to, the intervention that you have provided

Criteria..

4.5.1 You monitor and review the ongoing effectiveness of your intervention using recognised outcome measures where possible.

4.5.2 You take into account the opinions of your service users and their carers when evaluating the effectiveness of occupational therapy intervention...’

(College of Occupational Therapists, 2015)

Although the College of OT do not provide a definition for the term effectiveness in relation to professional standards, it clearly states the link between it and outcome measures and the notion of patient opinion. Despite much professional rhetoric to provide ‘effective interventions and discard what is not effective’ (Bannigan, 2004, p. 1), there is little clarification or agreement on definitions of what effective occupational therapy is. Explaining the American OT Federation’s call to prioritise research, Rogers states:

‘it is imperative that the efficacy and effectiveness of occupational therapy interventions be ascertained; that the optimal dose, frequency, duration and location of occupational therapy interventions be determined; and that the salient elements (or active ingredients) of occupational therapy interventions be identified’

(Rogers, 2010, p. 1)

Proposed research therefore seeks to investigate the phenomenon of ‘effective OT’ to identify what the active ingredients or salient elements of effective occupational therapy with CYP may be. Consequently, designing a phenomenological study which provides rich description of what actually happens in ‘effective OT’ is an important early step in illuminating and sharing OT practice. Allowing OTs working in the specialist area to describe what effective OT is will contribute a perspective which has, to date, been absent

from the professional body of knowledge. Defining occupational therapy, COT state:

‘Occupational therapists view people as occupational beings. People are intrinsically active and creative, needing to engage in a balanced range of activities in their daily lives in order to maintain health and wellbeing. People shape, and are shaped by, their experiences and interactions with their environments. They create identity and meaning through what they do and have the capacity to transform themselves through premeditated and autonomous action.

The purpose of occupational therapy is to enable people to fulfill (SIC), or to work towards fulfilling, their potential as occupational beings. Occupational therapists promote function, quality of life and the realisation of potential in people who are experiencing occupational deprivation, imbalance or alienation. They believe that activity can be an effective medium for remediating dysfunction, facilitating adaptation and recreating identity.’

(College of Occupational Therapists, 2009, p. 1)

‘The role of occupational therapists (OTs) with children and young people, is to promote their full participation in the occupations of everyday living.’

(Polatajko and Cantin, 2010, p. 415)

Background: Models of practice in OT

Creek (2003) provides a valuable overarching description of Occupational Therapy, its links with the ICF (World Health Organisation, 2001) and the processes used from referral to review of intervention. She also captures factors regarding the occupational therapist which influence OT practice, not least of all their knowledge and conceptualisation of occupation, which Creek went on to define as:

‘Occupation is a synthesis of doing, being and becoming that is central to the everyday life of every person and that provides longitudinal organisation of time and effort.’

(Creek, 2003, p. 32)

Recognising the importance of the thinking skill of the autonomous and accountable OT, she outlined various types of clinical reasoning, reflective/CPD skills and tools of practice that influence the occupational therapy offered to clients. Creek recognised the importance that external influences, such as the social context, as well as local and national policy have on practice.

OT theories and models of practice are widely published as core texts for under/post graduate OTs (Kielhofner, 2008, Creek, 2010, Rodger, 2010, Duncan, 2011, Turpin, 2011, Gillen et al., 2013, Bryant et al., 2014) and are not replicated here. The parameters of this study do not extend to a comparison of effective occupational therapy against the wide range of current occupational therapy models of practice. Consequently, references and links to models of OT practice are limited to their usage by participants in the study. Instead, the broader framework of the Occupational Perspective of Health has been used to provide an overarching context for the study in line with the current professional position (World Federation of Occupational Therapists, 2012b).

Effectiveness in Related OT Fields

A synthesis of international qualitative OT research (reported between 2000-2011), was carried out by Wimpenny et al. (2014). It sought to capture user, carer and OTs perceptions of the effectiveness of OT interventions used in mental health. Interestingly only eight of the twenty-two studies selected were from the UK, with children and young people excluded. Four themes were

identified: occupational engagement, professional artistry, new horizons (goals) and promoting inclusion. Of note is that over an eleven years period, only eight peer reviewed studies met the objective quality thresholds set and even with such low case numbers, no attempt was made to include child mental health, a point which will be discussed later. Other perspectives in OT in mental health (Morley and Rennison, 2011, Morley and Smyth, 2013), urge OTs to consider cost effectiveness, engage with how information technology supports providing underpinning evidence and the need to develop marketing skills to promote the value of OT in mental health.

In stark comparison, OTs in paediatric settings (OT with children with physical disabilities), have looked at improving children participation and performance and particularly with developmental co-ordination disorder (Morgan and Long, 2012, Bazyk, 2010, Dunford, 2008, Hyland and Polatajko, 2012, Poulsen and Ziviani, 2004a, Poulsen et al., 2007), and cerebral palsy (Kolehmainen et al., 2014). Use of occupational performance coaching (Graham, 2011, Graham et al., 2014, Graham et al., 2009, Graham et al., 2015, Kessler and Graham, 2015) to develop context and child focussed strategies aims to build capacity for context based intervention to optimise participatory outcomes for the children with disabilities. These studies are a selection of a much wider pool of paediatric research. The principle relevance being the contrast between the paediatric OT (physical) level of research activity and that of OT with CYP (mental health/LD). It is likely that lessons can be learnt through knowledge transfer (Pentland et al., 2013) regarding the applied use of ICF (World Health Organisation, 2001), occupational performance coaching and as the next section highlights, the arena of goal setting.

Self Determination Theory (SDT) and Goal Setting with CYP

Setting goals is a core skill of occupational therapists (Creek, 2003), as is attending to issues of motivation (Doble, 1988), finding common ground (Rosa, 2002, Rosa and Hasselkus, 2005) and promoting self-determination as a client centred profession (College of Occupational Therapists, 2011). Self Determination Theory (SDT) (Ryan and Deci, 2000) is a much cited and highly influential meta-theory of motivation, applied across a broad range of disciplines. SDT involves the facilitation of choice (A - autonomy), belonging (R - related ness) and mastery (C -competence), and consideration of contextual thwarts which may prevent people developing ARC.

Paediatric Development and SCOPE-IT

Significant progress in paediatric OT has been reported in relation to improving participation (World Health Organisation, 2001) through effective goal setting with young people (Kolehmainen et al., 2012). In particular, is the development of occupational performance interventions (Ziviani, 2015, Ziviani et al., 2014) through increasing self-determination.

Building on earlier work Poulsen and Ziviani (2004b), introduced the SCOPE-IT Model (Synthesis of Child, Occupational Performance and Environment In Time) (Poulsen and Ziviani, 2004a), based on self determination theory, (linked to occupational performance, and the environment), with children with Developmental Coordination Disorders (DCD). Further publications have honed and provided expansive examples of how to apply SCOPE-IT and SDT

within different OT models (Ziviani and Rodger, 2006, Rodger, 2010, Ziviani et al., 2014, Poulsen et al., 2014, Poulsen et al., 2015). More recently, (Ziviani, 2015) has urged the wider occupational therapy community to consider self-determinism as core to all OT practice and retro-fitting SDT to established OT protocols. The argument being that the facility to describe how OT is done, could advance research on the efficacy of intervention and be a significant step towards reporting on the effectiveness of occupational therapy.

Summary

Understanding effectiveness within the OT practice realm has enabled national statutory obligations to be contextualised. Research from the related fields of adult mental health OT and child physical health OT have identified salient concepts of effectiveness in these areas. Variance in cultures of research outputs have been noted between MH/LD and Paediatric OT and the potential for closer collaboration in the future will be discussed in chapter nine.

Conclusion

This narrative literature review (Green et al., 2006) chapter, has synthesised previously published information relevant to the study of effectiveness in occupational therapy practice with children. Looking firstly at the international conceptualisation of health, section one looked at the World Health Organisation (1998) stance and the associated International Classification of Functioning (World Health Organisation, 2001). Alongside this framework the Occupational Perspective of Health (OPH) (Wilcock and Hocking, 2015) has been outlined along with the World Federation of Occupational Therapists (WFOT) statements which guide the profession globally. Legislation within the NHS in England has been investigated together with key policy drivers affecting mental health and learning disability service providers encapsulated in the new Five Year Forward View for Mental Health (NHS England, 2016b).

Section three looked at the quality agenda and the many references to effectiveness and little provision definitions of terms. Section four focussed on the field of occupational science and its call to OTs to be ambassadors for occupational justice and explored the concept of occupational performance (Wilcock and Hocking, 2015).

Section five contextualised the place of OT models of practice, within this study and explored evidence from mental health services as to what constitutes effective OT for the adult population (Wimpenny et al., 2014). Finally, recognising the core skills of OT in helping CYP to set goals, examples have been provided from paediatric OT, where significant advancements in applying self-determination theory are enabling young people to participate more fully

in life, an early finding which has the potential to enrich the lives of CYP with MH/LD.

The requirement for OTs to attend to matters of effectiveness in relation to the occupational therapy they provide to children is clear and the absence of literature to evidence that such activity is taking place, highlights the gap in current knowledge and urgent need address this deficit.

Chapter Three: Methodology Chapter

Introduction

Having established the need to study the phenomenon of effective occupational therapy, this chapter will explain and justify the underpinning phenomenological philosophy used in this research to address this aim. The relativist ontological stance (Wilding and Whiteford, 2005) of this research, with its search for truth through the experience of occupational therapists and the meaning they ascribe to the phenomenon of effective occupational therapy, is detailed. Assuming an interpretivist epistemological perspective (Denzin and Lincoln, 1994, Lincoln and Guba, 1985), this study acknowledges and celebrates the researchers' role in interpreting the information received from the OT participants. Consequently, the chosen interpretive phenomenological methodology (Heidegger et al., 2008) is explained, providing a reasoned segue into the next chapter detailing the methods chosen to ensure congruence between methodology and methods.

Firstly, looking to the realms of positivistic and naturalistic inquiry, fundamental epistemological and ontological understandings are appraised against the focus of enquiry. The spectrum of qualitative enquiry and particular methodologies are considered in terms of their fit with the research aim. Key aspects of phenomenology are then set forth, including interpretive phenomenology and the various schools of thought within it. The underpinning methodology chosen for this study is provided.

Embedded within this interpretive position, increasingly interpretive levels of methodology will be undertaken, in order to obtain a full and in-depth analysis of the phenomenon of effective occupational therapy with CYP. The rationale

for the increasingly interpretive nature of it will be provided: starting with an initial thematic analysis, progressing to the use of Lifeworld themes (Ashworth, 2003) and culminating in a metaphorical consideration of findings. The subjective nature of interpretive phenomenology, the reflexive relational approach (Finlay and Evans, 2009) to be taken, will be detailed. Finally, a summary of the methodology used and whether it addresses the research aim and objectives will be provided.

Methodological Approach

Quantitative or Qualitative Research?

It is crucial to first clarify the purpose of the research at the outset, as this is the primary determinant of methodology (Richards and Morse, 2013). The purpose here is to explore the phenomenon of 'effective occupational therapy' with children and young people (CYP) with mental health and or learning disabilities (MH/LD), through the lived experience of occupational therapists. This is an area where there is very little up-to-date or clinically relevant knowledge (Miller et al., 2007, Scaletti and Hocking, 2010, Arbesman et al., 2013, Bazyk, 2011).

Subsequently, a brief summary of three main issues from the introduction and literature review will be provided. In its embryonic form, this investigation was initially conceptualised as a positivistic research study into current use and effectiveness of clinical outcome measures used by OTs in the field of CYP. Three key issues mitigated against this approach.

Firstly, there is an absence of routine data collection regarding the use of OT outcome measures at local NHS service level, which makes it impossible to

collate and appraise through NHS data collection systems. Those outcomes that are routinely collected are patient-focused and not specific to any particular intervention, thus unable to capture detailed information of the effectiveness of occupational therapy. The OTs perspective is not captured and as Finlay (2011) acknowledges, data from outcome measures may not inform practice or capture the value of practice.

Secondly, utilising methodological reflexive skills (Finlay, 1998), it became evident that such a managerialist perspective (Robertson, 2012) to understanding the use of outcome measures (O/M) (Unsworth, 2011) to demonstrate the clinical effectiveness of services (Fuller, 2011) had limitations. Not least the assumption of there being an ordered, objective existence, which holds a measurable truth about what effective OT is. In the absence of previous studies reporting on effective OT is, how can it be known that the outcome measures selected by OTs are capturing the right things?

Thirdly, the review of literature, unlike adult mental health OT, found no systematic reviews of effectiveness and a few studies relevant in terms of mental health but not specific to the more complex presentations found in Tier 3 and 4 services in NHS England. Specialist CAMHS Services have changed markedly over the past 25 years in response to increasing acuity and prevalence, the integration of learning disability and commissioning divided across newly created local and national bodies.

Consequently, this study is looking at the phenomenon (effective occupational therapy with children and young people) as it presents itself now, in all its

breadth and depth, without imposing methodological constraints, which could hamper a fresh and nuanced understanding of it.

To capture the complexities of these therapeutic and social interactions a qualitative approach (Denzin and Lincoln, 1994), which embraces the richness of the phenomenon under investigation was selected, rather than take a quantitative, reductionist approach (Finlay, 1998). It is hoped that findings will reveal useful insights into the concept of effective occupational therapy upon which to build a more robust body of knowledge in a well-established, but largely unpublished, clinical specialism.

Qualitative Methodological Options

Following the review of literature, which identified multiple calls for practitioners to be more effective, it became clear that the purpose of this study needed to embrace the much-used but rarely defined concept of effectiveness. There is a need to develop the meaning of these concepts as they apply in CYPS MH/LD OT practice. This is a complex clinical area, with ever-changing priorities and requirements, so using a qualitative approach will allow an airing of a dynamic phenomenon. This is a challenging, if not impossible, task for a positivistic approach. Put simply, there is not enough known about the phenomenon under investigation, that would allow experimental parameters to be set around it for positivistic analysis. Such an analysis would be pre-emptive and stifle broad understanding at this early stage of creating a platform from which other studies may build, using other methodological approaches.

The benefit of qualitative research capturing the experience of OTs who have worked in the clinical area for years, is that it enables these new ways of seeing (Richards and Morse, 2013) the familiar. By choosing a qualitative methodology which enables effective occupational therapy to be foregrounded (Finlay, 2011) in a culture where the dominant NHS discourse regarding effectiveness is the use of positivistic outcome measures, there is an opportunity to create new learning and insights which, in turn, contribute to the effectiveness agenda. Qualitative methodology has been selected for this study as it resonates with the main purpose, which is to understand the phenomenon of effective OT deeply, allowing discovery of key themes and the airing of professional understanding.

Having identified that the qualitative research paradigm is aligned to the purpose of the research, Richards and Morse (2013) suggest a second principle of methodological congruence to describe the inter-relatedness of the identified problem, the aim and methods, so that the best possible answer is provided. Congruent methodology is evident in that a complex and unstudied problem has emerged from professional, clinical and statutory imperatives. The qualitative methodology selected for this research will illuminate practice which has hitherto been hidden from academic scrutiny.

Choice of Qualitative Strategy

Within the spectrum of qualitative research there are a range of approaches which Richards and Morse (2013) summarise as: ethnography, grounded theory, phenomenology, discourse analysis, participatory action research and case study.

Ethnography

An ethnographic study of 'effective OT' would involve the day-to-day description of effective OT in different environments, activities and relationships. Participants could be anyone with a view of effective OT and such an approach is likely to result in capturing perspective, or peoples own analysis and interpretation. What is sought by the research aim of this study are meanings of the experience (Crotty, 1996), their apriori experience, not an analysis of their own experience. Getting to the raw experience is the natural attitude sought by phenomenological research, which reflects the research aim of this study.

Participatory Action Research

As a 'silent voice' in the literature, some consideration was given to adopting a Participatory Action Research (PAR) methodology. The principle issue here was the research aim, which arose from practice and literature and which clearly related to a specific topic: effectiveness and occupational therapy. Whilst an empowered methodology for an under-represented group is philosophically attractive, it requires the research aim to be established collaboratively and investing time in allowing all participants to influence and shape the research study, the area of enquiry and methods of achieving the research aim. Having already established the area of enquiry and aim, it would have been ethically disingenuous to then go to participants with the intention of persuasion. However, insights from this study could inform a future PAR study.

Generating Theories

Rather than focus on a process associated with 'effective OT', which could have been carried out using grounded theory methodology, this study focussed on keeping a wider perspective, and capturing the lived experience of OTs. (Kielhofner, 2005), the founder of the Model of Human Occupation, guarded against occupational therapists doing small scale studies developing more theories where a more collaborative approach could progress the profession further.

For this study, the added value of insider researcher position was felt to be one which could facilitate the ideas of others, rather than to collate and refine a theory, albeit grounded in the data.

Summary

This section has highlighted key thinking in the design of the research carried out. Starting with the epistemological differences in qualitative and quantitative approaches, it was clarified that the underpinning approach is one which does not seek an objective truth or singular vision of what effective OT is. Rather this qualitative study recognises reality as subjective and mentally constructed. By researching a human phenomenon, it recognises the researcher as interactive within the study, with values which inevitably impinge on it, and whose value can be captured through analysis and reflection. The process of developing new insights and knowledge about effective OT is through a qualitative design with inductive processes, building up a picture of this constructed reality (Johnson, 2007).

Phenomenology

This study focussed on gathering rich descriptions of effective occupational therapy with children, from the perspective of the occupational therapists working in this specialised field. With its emphasis on the natural state (van Manen et al., 2016), phenomenology allows for the study of a phenomenon without conceptualisation or categorisation and has therefore the best fit with this research aim.

Phenomenology, Occupational Science and Occupational Therapy

Finlay (2011), an occupational therapist and psychotherapist, recognised the politically laden call for evidence of effectiveness, suggesting phenomenology as a bridge between dry academic research and clinically relevant, practice-informed research. How best to study human occupation remains a key issue for occupational scientists, with much debate around qualitative approaches and phenomenology in particular (Reed et al., 2010).

Park Lala and Kinsella (2011) provide a candid and insightful synopsis of the debate in recent times and the challenges faced by occupational scientists in using a phenomenological approach. They principally note the time and effort required to fully engage in first-hand writings of founding phenomenologists and the lack of training to unpick the nuances of a complex and necessarily changing philosophical movement and related field of science (Finlay, 2011). These concerns about second-generation referencing (Park Lala and Kinsella, 2011) of complicated phenomenological constructs being misconstrued, is echoed by Paley (1998) in the nursing literature. He recognised that modern-day interpretations and ongoing discussion of research into lived experience

can deviate from original concepts and are, in themselves, becoming a social construct within some professional groups. Tuohy et al. (2013) provides a valuable overview of interpretive phenomenology building on the comprehensive work of Dowling (2007), who identified key differences between old and new phenomenology.

Nevertheless, Paley (1997), Park Lala and Kinsella (2011) and Finlay (2011) all recognise the value of capturing real-life experience (Todres et al., 2007, Dahlberg et al., 2009, Dunne and Pettigrew, 2013) and urge greater awareness of the central constructs of phenomenology (Rich et al., 2013). They appear to represent a new generation of those endeavouring to present phenomenology in a way that clarifies pivotal constructs coupled with adherence to original thinking, in a more accessible language for modern-day researchers. Moving beyond their appraisal of the insufficiency of general qualitative texts, this second generation of researcher educators are attempting to bridge the time-pressured environment of modern research endeavours, to provide more in-depth, accurate and succinct explanations of the scientific application of phenomenology to the research of lived experience.

As a critical recipient of such teaching through extensive study of phenomenology within OT (Lin et al., 2009, Reed et al., 2010) and the wider professional/theoretical context (Van Manen, 1997a, Dahlberg, 2006, Biley and Galvin, 2007, Crowther, 2011, van Manen et al., 2016), it is ethically important to acknowledge, that the original German versions of Heidegger's writings have not been a primary source of information. Indeed, without such interpretive texts (Park Lala and Kinsella, 2011, Finlay, 2011), even the English translation of Heidegger's seminal work (Heidegger, 1962) would have been

impenetrable without further extensive study not available to a part-time professional doctoral clinician, working full time. As a clinician, such texts are an important translational step in orientation towards denser, philosophical explanations of methodological underpinnings, described here by a clinical phenomenological academic seeking to support such a journey:

'I want to navigate a simple path that will guide my readers sure-footedly through this shifting, boggy landscape with its myriad contested ideas and experiences.'

(Finlay (2011, p. ix)

Descriptive Phenomenology & Husserl

Phenomenology offers an important opportunity to return to Husserl's notion of "back to the things themselves" (Glendinning, 2006), especially where there appears to be no previous study. Epistemologically, this form of enquiry will provide formative knowledge through text, understandings and an enhanced perception of what the phenomenon of effective OT is. Husserl, the modern philosophical founder of phenomenology, described the search for "essences" (Finlay, 2011), through adopting a phenomenological attitude – or bracketing – of prior assumptions and scientific theory and knowledge. Ontologically, this study is not seeking to find an absolute truth, but to gain insights into the lived experience of OTs working with this CYP.

Interpretive Phenomenology & Heidegger

This study uses an interpretive phenomenological approach, exemplified through consideration of five central tenets, which have arguably remained central to the philosophy of phenomenology over time (Dowling, 2007):

‘(a)knowledge generation, (b) intentionality and the Lifeworld, (c) *Being*, (d) the lived body, and (e) first critique.’

(Park Lala and Kinsella, 2011, p. 196)

The aim of this research is to generate new knowledge from first-hand accounts given by OTs, putting aside a critique (phenomenological reduction) of what is said in order to see the phenomenon of effective OT afresh in the environment as it is lived everyday (natural attitude, being in the world) by OTs in CYPS. Based on the philosophy of phenomenology, this study will take an hermeneutic phenomenological approach (Palmer, 1969) where hermeneutics from a Heideggarian perspective can be defined as:

‘the theory and practice of interpretation. ...To interpret a text is to come to understand the possibilities of being revealed by the text.’

(Van Manen (1990, pp. 179-180)

Hermeneutic phenomenology:

‘tries to be attentive to both terms of its methodology: it is descriptive (phenomenological) methodology because it wants to be attentive to how things appear, it wants to let things speak for themselves; it is interpretive (hermeneutic) methodology because it claims that there are no such things as uninterpreted phenomena. The implied contradiction may be resolved if one acknowledges that the (phenomenological) “facts” of lived experience are always already meaningfully (hermeneutically) experienced...even the “facts” of lived experience need to be captured in language... and this is inevitably an interpretive process.’

(Van Manen (1997a, pp. 180-181)

Ethical considerations, data gathering and analysis will be aligned under the umbrella of this Heideggerian interpretive phenomenological approach (Heidegger, 1962). To be methodologically clear, this study captures descriptions and reports on them thematically, within this definition of Van Manen (1997a) of all descriptions being interpretive.

Husserl's phenomenological attitude is the process of managing the intrusion of pre-understanding (Finlay, 2011), where the researcher aims to be fully present, holding "in abeyance" (Giorgi, 1986) past knowledge and existential claims, bracketing previous knowledge and focusing on meaning as given. Going beyond the idea of bracketing this study assumes an openness – the capacity to be surprised and, embracing humanistic values, awed and open to a shift in understanding, described by Finlay (2011) as empathic dwelling. This acknowledges the potentially oppressive power position in the role (Finlay, 2005) as researcher and makes a deliberate move from researcher focus to participant focus.

Critique of Interpretive Phenomenology and Methodological Variance

Critique in interpretive methodologies is well reported within psychological (Giorgi et al., 2003, Giorgi, 2011, Smith, 2015), and nursing research (Benner, 1994, Alasad, 1997, Caelli, 2000, McNamara, 2005). This research will not be using an Interpretative Phenomenological Approach (Smith, 2015) with its associated, albeit contended, guidance of a prescribed method of doing interpretive phenomenology. Rather, the methodology of interpretive phenomenology will serve as an overarching framework within which the Lifeworld of occupational therapists will be explored. To illustrate how this will be contextualised, the following section outlines the Lifeworld and the contributions of Van Manen (1997a) and Ashworth (2003) to this field of work and their influence on the design of this research.

Summary

This research draws upon the methodological school of phenomenology, stemming from the original thinking of Husserl and developed via the interpretive phenomenological work of Heidegger (1962) and Gadamer (1979) creative interpretive extensions into using art. The use of this methodology, amongst other qualitative approaches, is advocated by occupational scientists (Park Lala and Kinsella, 2011) as, despite its complexity, an important way to capture lived experience and further the pursuit of knowledge of human occupation.

This study is firmly within the interpretive school of phenomenology, meaning that clarity over Van Manen's definition of the term 'descriptive' in relation to hermeneutic phenomenology has been emphasised to maintain methodological rigour.

The increasingly interpretive methods used within this research will be outlined in the next section and reflections of the challenge of carrying out such research are reported later in the Reflexivity Chapter.

Lived Experience and the Lifeworld

Lived experience relates to the pre-reflective state of being aware of life without thinking about it (Van Manen, 1997a, Crowther, 2013, Paley, 2014, Heidegger et al., 2008). The Lifeworld is the world just as it appears (Dunne and Pettigrew, 2013, Dahlberg, 2006), as lived, pre-reflectively. Taking a Lifeworld approach (Finlay, 2013, Todres et al., 2007), this study will explore how everyday experience shows itself as embodied and lived in time and space –

and in relationship with others (Van Manen, 1997a). The aim of this study is to capture the lived experience of occupational therapists working in this specialist area, as they describe particular occupational therapy sessions, which appeared to them to be effective.

Ashworth & Lifeworld

Ashworth (2003) contends that:

'Lifeworld as such refers to an essential structure fundamental to human experience...the Lifeworld has essential features and is a human universal.'

(Ashworth, 2003, p. 146)

In this seminal work, Ashworth outlines the phenomenological roots of his claim and goes on to outline seven essential structures – or fragments - common to all Lifeworld: self-hood, sociality, embodiment, temporality, spatiality, project and discourse. These fragments, he posits, can be considered in relation to any situation described in the Lifeworld. Ashworth's concept of self-hood relates to social identity, sense of agency, presence and voice. Sociality includes a concept of relations to others and spatiality to the geography of place, or environment. Temporality relates to time, duration and biography. The Lifeworld concept of project considers how the situation relates to the person's ability to carry out activities which are central to their life and to which they are committed. Embodiment relates to physical feelings, bodily sensations, emotions and disabilities. Finally, discourse relates to the kinds of social, educational, ethical terminology used to describe and live the situation.

Ashworth (2016) reiterates the opportunity to enrich phenomenological research and the descriptions they offer of a phenomenon, through the active investigation of these fragments, including the additional concept of

moodedness. Countering the argument that such a pre-supposition of Lifeworld fragments is an anathema to the *epochè* and bracketing, Ashworth suggests (2003, 2016) the concept of these being essential elements found in any lived environment.

Consequently, one of the objectives for this study is to analyse the lived experience data and identify any Lifeworld fragments. Consequently, as well as inductively analysing the descriptions given by OTs, Ashworth's fragments will be considered to further analyse these descriptions. It poses the supplementary query: does the phenomenon of effective occupational therapy relate to self-hood, project, temporality, sociality, spatiality, embodiment and discourse?

Metaphor and the Arts

Seeking to increase understanding through narrative and metaphor (Ricoeur and Thompson, 1981), a hermeneutic approach will be taken to interpret the texts, as derived from transcribed interviews. The value of expressive writing to capture and evoke the experience being investigated is outlined by Van Manen (1997a), who advocates for an artistic element to writing up findings, as they have touched the researcher. This is supported by the insights of Finlay (2011) on the use of metaphor by hermeneutic phenomenologists and the evaluation of such research being its value to move the reader through literary and artistic means:

'the best articles are resonant, textured and wield emotional power... that challenges, unsettles and disturbs normal taken for granted complacency...allows new and deeper views into the worlds of others'.

(Finlay, 2011, p. 270)

Seeking to expand the approach to exploring the phenomenon of effective occupational therapy with CYP, an objective of this research is to gather metaphors from participants of 'effective OT'. These metaphors will be inductively analysed and an interpreted summative metaphor will be presented which seeks to capture the phenomenon.

Summary

This section has detailed what lived experience and Lifeworld is, within the frame of reference of interpretive phenomenology. It has outlined Ashworth's argument to appraise whether a given situation relates to Lifeworld fragments (Ashworth, 2003, Ashworth, 2016). Finally, it has outlined the relevance of the Lifeworld, to the study objective: to identify themes and fragments which may enable the meaningfulness of effective OT with CYP to emerge. Finally, it has outlined the drive to capture metaphors from participants, which capture the meaning of effective OT for them and provide an interpreted summative representation to foreground the meaning of effective OT.

The Therapist Insider Research: Reflexive Relational Approach

Finlay and Evans (2009) relational centred research approach will be taken, where the researcher-participant relationship is explicitly examined. This premise acknowledges that a researcher-participant relationship is two-way and that experienced clinical communication and relational skills are useful to foster openness... with curiosity, empathy and compassion' (Finlay, 2011, p. 166). Within the reflexive relational approach, subjectivity is celebrated and understandings are co-created and embodied (Finlay, 2011).

Key to the success of this approach is the researchers' reflexive skills, where critical self-reflection happens throughout the study and is recorded and analysed as part of the overall research process (Finlay and Gough, 2003). A reflexive journal will be used to record and mitigate for increased levels of relational dynamics and questioning, and will serve as a source of data in itself. To strengthen the trustworthiness of the identified approach and its findings, an in-depth reflexive analysis will be undertaken, using journal data to theme and illuminate researcher subjectivity.

Approaches to Reflexivity

This section explores the various approaches to reflexivity within qualitative research. It clarifies the definition and concepts relating to reflexivity. In the light of the research aims, it illuminates critical issues, thereby allowing the reader to assess the credibility and openness of the research undertaken. There is a growing body of agreement regarding researcher influence on a study (Finlay, 2002a, Probst, 2015, Berger, 2015), both positive and negative,

which requires careful and active consideration. As an insider researcher it is important to recognise our own historical and cultural understanding, prejudices, and horizons (Gadamer, 1979).

Finlay posited that the researcher influences the research through their position, perspective and presence (Finlay, 2002b). This analysis will cover the three research phases identified as: pre-research; data collection/gathering; and data analysis. Evidence will be presented from source material including transcribed researcher diaries, project documents, university submitted supervision records and participant transcripts. Drawing upon Finlay's (2002a) conceptual map of reflexivity, each stage of the research process will be discussed, drawing insights from the five categories of reflexivity identified as relevant to qualitative research. As a result of this reflexive analysis, the themes will be synthesised into a summary of key insights. The purpose of such an exploration is to allow the reader to critically appraise the trustworthiness (Lee, 2009) of the research undertaken and provide a transparent (Guillemin and Gillam, 2004) account of the researcher position within the research.

It is important that consumers of research are able to assess its authenticity, this being a primary aim of the practice of reflexivity (Probst, 2015). The terms reflection and reflexivity have been well researched and reported on (Schön, 1983), particularly the concept of reflection in and on practice. The term reflexivity (Finlay, 2008, Finlay, 2002a, Lee, 2009) is used in research to make clear to others the nature of the researcher's interaction with the research. Various types of reflexivity (Wilkinson, 1988, Finlay and Gough, 2003), have been identified. Underpinning much of the debate is the post-positivistic view

of qualitative research and the re-conceptualising of the term researcher bias, from being problematic and to be eradicated, to being embraced as an important academic recognition of the positioning of the researcher in the research (Darawsheh and Stanley, 2014, Gemignani, 2011). Reflexivity acknowledges the co-createdness of qualitative research.

Assessing Reflexive Accounts

Probst (2015) developed reflexivity discussion by going beyond the established focus on defining terms (Pillow, 2003, Finlay, 2002a), usage (Ben-Ari and Enosh, 2011) and classification (Barusch et al., 2011), to studying how and why social worker researchers engage in reflexivity. In an attempt to assist the reader on how to assess a reflexive account, she suggests they consider the author's agenda, a revised process, inter-subjectivity, self-interrogation and evidence of an audit trail of how the author tracked decision making and interpretations. To aid analysis of the reflexive element of this research, chapter eight is structured using Finlay's (2002a) summary of six principle components of reflexivity: introspection, inter-subjective reflection, social critique, mutual collaboration, co-construction and discursive deconstruction.

Summary

This section has outlined the reflexive relational approach (Finlay and Evans, 2009) used in this research, which enables the clinical skills of the researcher to be used to encourage the participant to describe in detail their experiences. The in-depth analysis of reflexive methodologies indicated key issues which have emerged in recent years and how to enhance the trustworthiness of qualitative research through the use of reflexive tools.

Conclusion

This chapter has appraised the reasoned selection of interpretive phenomenology (Van Manen, 1997a) as a methodology which can address the research aim and objectives. The underpinning epistemology and ontology of this study have been discussed along with the rationale for increasingly interpretive levels of data analysis. Methodological considerations regarding the approach to this study have been appraised in the light of the alternative methodologies which were considered. Stemming from the initial thematic analysis, data analysis will include the use of Lifeworld themes (Ashworth, 2003) and culminate in a metaphorical consideration of findings. Acknowledging the subjective nature of interpretive phenomenology, the reflexive relational approach (Finlay and Evans, 2009) to be taken has been explained.

As discussed earlier phenomenon of 'effective occupational therapy' with children suffering from problems related to their mental health and/or learning disabilities has been hidden from academic understanding, despite statutory requirements for therapists to provide effective OT. Whilst other methodologies will no doubt progress this understanding beyond this study, this initial illumination of the phenomenon is essential in bringing the subject into the foreground as a starting point from which to build the body of knowledge in this clinical area.

Chapter Four: Methods of Data Collection and Analysis

Introduction

Progressing from the methodological decisions to use an interpretive phenomenological approach, this chapter discusses how these approaches are translated into design and implementation.

Having already established the rationale behind the research aim and first objective, this chapter outlines how aims two to five will be met through the design of the study method. Specifically these relate to: data collection from a specific group of professionals; analysis of themes and Lifeworld fragments; interpretation of data from an occupational perspective of health (Wilcock and Hocking, 2015); and the gathering of metaphors.

Part one will outline the research design and method of data collection. Part two will focus on data analysis methods and phases of increasingly interpretive exploration of the data.

Part One: Research design and method of data collection

Research Design

Design

A reflective analysis was undertaken in the pre-research phase as part of the process of developing a robust design.

‘...researchers could fruitfully examine their motivations, assumptions, and interests in the research as a precursor to identifying forces that might skew the research in particular directions. This stage is a particularly crucial one in phenomenological research as the researcher prepares to approach the phenomenon to be investigated with openness and wonder—the attitude fundamental to this method.’

(Finlay, 2002b, p. 536)

The reflexive account was included as part of the submission to the university ethics panel (see Appendix 2) and explored: power differentials; potential for coercion; and pre-conceptions regarding what effective OT is. This research aimed to minimise such issues through rigorous design as well as step-by-step reflexivity on the process, which is further explored in the reflexivity chapter later.

Lived Experience

In order to keep fidelity to the research aim an interpretive phenomenological paradigm was used to provide a framework within which methods were selected. Central to this endeavour is the focus on capturing a pre-reflective state, endeavouring to stay close to the experience of ‘effective occupational therapy’, as it is immediately lived (Van Manen, 1997a). Various methods of collecting such information are available with consideration given to the options of written, verbal and/or observational methods.

‘In hermeneutic phenomenology human science the interview serves very specific purposes: (1) it may be a means for exploring and gathering experiential narrative material that may serve as a resource for developing richer and deeper understanding of a human phenomenon, and (2) the interview may be used as a vehicle to develop a conversational relation with a partner (interviewee) about the meaning of an experience.’

(Van Manen, 1997a, p. 66)

Conversation, guided by a clear aim, seeks to capture personal stories which can be recorded and written into text, which then become data to be analysed. Concrete examples of specific OT sessions, with descriptions of the actual session and what was going on, were sought through dialogue. There are risks associated with written methods where the participant is required to record their experience, which may evoke more a reflective, analytical response (Van Manen, 1997a). Observational methods are problematic in relation to the research aim, which is seeking the experience of effective OT sessions. With no evidence to support how (in) frequently this may happen, there could be many hours of no directly-relevant data. Such an endeavour would be more aligned to an ethnographic approach, developing rich descriptions and taxonomies (Richards and Morse, 2013), but this would not meet the phenomenological touchpoints crucial to this research.

The second point on developing conversational relations about the meaning of ‘effective OT’ is an important aspect of realising the reflexive relational approach (Finlay, 2011) discussed in the methodology chapter. Occupational therapy in MH/LD and psychology are closely-aligned disciplines within CYPS, with shared professional understandings of psychodynamics and psychotherapy. Drawing upon these skills (Finlay and Evans, 2009) and

maximising the conversational relation provides the opportunity to explore meanings beyond a superficial exchange.

Consequently, the decision was made to conduct face-to-face interviews, in an environment of the choice of the participants.

Sampling Strategy

To satisfy the research aim, the scope of this sample (Richards and Morse, 2013) prescribed a selection criteria of occupational therapists with lived experience of providing occupational therapy to children and young people with mental health and/or learning disabilities within specialist community services and in-patient services (mainstream or forensic), in the NHS in England. Consequently a purposive sampling approach (Wilson and Hutchinson, 1991) was taken, which allows for participants who can provide rich descriptions of 'effective OT' to be chosen. Despite the study seeking a small number of approximately eight participants (Ritchie et al., 2014), consideration of drawing from a national pool of such OTs was made, but no central register of CYPs OTs exists, so the population is practically impossible to identify and access. Whilst the College of Occupational Therapists has a specialist section, especially for Children, Young people and Families, MH/LD OTs are significantly under-represented within it, with a dominant discourse of physical paediatric OT. A well-established CYPs OT service was identified, from which participants were invited to express their interest in involvement following an advert. If necessary, the sample size could be extended beyond the original eight, should they be required. For this purpose, ethical approval

was sought for up to fifteen participants, though this would be unusually high for an in-depth hermeneutic phenomenological study using a reflexive relational approach, the thinking being that the relational aspect of the encounter, coupled with strong clinically-transferable interview skills, is likely to generate a large amount of rich and meaningful data. Experienced reflexive relational researchers (Finlay and Evans, 2009) point towards sample sizes of 4-6 for doctoral level study. The sample size of eight, as a relatively inexperienced reflexive relational researcher, allowed scope to extend the sample size (up to fifteen) should the research aim and objectives require it, and reduce transcript inclusion if necessary (if research aim sufficiently satisfied). Ethical approval also allowed for participants to be re-interviewed if greater clarity was required post-initial analysis, which all participants agreed to but were not required for.

Ethical Approval

Ethical approval was given by the University (see Appendix 7) for a sample size of between 8-15, seeking to maximise variation (Baker and Edwards) in terms of: professional experience, OT approaches used and mental health/learning disability conditions.

In the spirit of reflexivity (Appendix 2), ethical issues were actively considered throughout the design of the study and can be evidenced in documents that gained ethical approval in the light of the assurances they provided. These included: Participant Information Sheet (Appendix 4); Debrief Advice Sheet (Appendix 5); Interview Question Schedule (Appendix 6); Ethics Approval

Letter Northumbria University (Appendix 7); Informed Consent Form (Appendix 8).

Data Collection: Preparation Phase

Implementation Planning

A Fieldwork Gantt Chart (Appendix 3) was used to prepare for the implementation of the designed research. Outlining processes and timescales to guide the research enabled thorough planning and preparation. Ethical approval was received from the university and NHS Trust where OT staff was being accessed. In order to mitigate for the researcher's "insider position", the project administrator acted as an intermediary and sent electronic copies of the explanatory advert/ flyer to all staff individually and collated queries and responses.

Participant Information Sheet

The Participant Information Sheet (PIS) was provided, as outlined in the Ethical Approval Process, and details of interested participants were collated on a contact information sheet. A brief explanation of the concept of the phenomenological attitude was provided on the PIS, to assure participants that their contribution would not be judged, but captured and analysed in a way that ensures an openness and empathy with their narrative.

Risk Assessment

Compliance to the approved risk assessment procedure was assured and changes to the environment were made prior to arranging interviews, following

a request for any special needs to be identified in advance. As a result one interview was re-arranged for level access to enable full participation, with access to facilities as required. Participants were informed that their comfort and safety were of prime importance and opportunities to stop or suspend an interview were extended to all. No participants elected to leave or interrupt the session.

Practicalities and Technology

Digital recording equipment was procured prior to interviews and checks were made prior to sessions that sound quality was acceptable and that file transfer by administrative support staff would be possible post-interview. Agreements for administrative staff to send digital files of interviews were made, with the researcher having responsibility for transcribing interviews. Clarity regarding information governance issues was made, with systems of transferring data in encrypted form being made prior to going live on the fieldwork. Informed consent forms (Appendix 8) were printed and available prior to sessions, should any points require clarification.

Debriefing & Reflexivity

Debrief advice sheets were printed and available for distribution after each interview, along with an offer of support post-interview should that be needed. The researcher had an agreed reflexive diary format which was used after each interview and is discussed in the Reflexivity Chapter.

Interviews and Financial Support for OT participants

Having determined that face-to-face conversations were the optimal method of hearing about the lived experience of OTs, practical arrangements were made through a research administrator. Permission was received from the Service Director that OTs attending interviews could claim travel expenses and take the time out of their clinical practice to contribute to the study. Dates and venues for interviews were negotiated with the project administrator, for the convenience of staff and to minimise service disruption to the CYP. This pre-research phase outlined by Finlay (2011) is crucial in relational ethics: to establish trust, respectful collaboration and to set the scene for a fully-informed, ethical process.

Data Collection: Fieldwork Phase

Informed Consent

Participants attended on a set date for a 45-90 minute, in-depth interview. The session commenced with a recap on the PIS and was referred to prior to all interviews being recorded, with several participants saying they had not had a chance to read it beforehand, so a fully-informed discussion of the expectations and responsibilities was conducted. This included clarification of the right to withdraw at any time and for interviews to progress without being recorded, if this was a preferred option. Signed informed sheets were collated and securely stored by the researcher.

Approach

A non-directive approach was used during the interview with the aim of eliciting as much descriptive detail as possible. Participants were invited to use whichever means they wished to explain their lived experience of effective OT with CYPS. Resonating with the study of the art and science of OT in CYPS (Williams and Paterson, 2009), participants were invited to describe their meanings in creative terms, e.g. including the use the of metaphors to summarise their descriptions.

Debriefing

A Debrief Advice Sheet was given to each participant at the end of the interview. After completion of individual in-depth interviews with 8 participants, follow-up interviews were arranged if necessary, face-to-face or by phone, for

points of clarification. Participants were asked if they wished to have access to the final results, which everyone requested.

Final Sample Size

As discussed previously, the sample size is challenging for the level of in-depth descriptive analysis required by the reflexive-relational approach taken (Finlay and Evans, 2009) and the subsequent depth of interpretive analysis (de Witt and Ploeg, 2006, Van Manen, 1997a). To facilitate this, the initial stages of data analysis commenced as soon as the first interview was complete, with the transcription process being an important stage of immersion in the data and allowing time and space to 'dwell with' (Finlay, 2011, p. 229) the material. The need to maintain high-quality, timely analysis, interpretation and accurate reporting of conclusions and effective evaluation (Finlay, 2006) resulted in a sample size of eight, to allow for critical appraisal of the content, process and progress during the data gathering phase.

Summary

Part one has detailed the design of the research and methods of collecting data. The design satisfies the research aim to explore the phenomenon of effective OT through the lived experience of OTs. It allows for objective two to be satisfied by gathering data from OTs experienced in working in these specialist services in the NHS in England. The Gantt Chart, submitted as part of the ethical approval process, shows the three phases of the design, from

preparation to data collection to data analysis, and indicates a meticulous approach to the fieldwork phase.

Part Two: Data Analysis Methods and Phases

This section outlines the framework used for the analysis of the data gathered.

In particular, the process by which the descriptive analysis was undertaken is provided and the method of interpretive analysis which followed outlined. The metaphorical analysis will also be described.

The four stages of this phenomenological approach, assuming a phenomenological attitude, immersion in the data, integration of the whole and using language to evoke the phenomenon, were systematically undertaken (Finlay, 2014). The final analysis uses increasingly interpretative methods, such as metaphors to interpret the meaningfulness of the descriptions from the existential lens (Finlay, 2013) of the Lifeworld (Van Manen, 1997a).

Data analysis commenced with transcription of the first interview and engagement with the data as it stood. Descriptive analysis was undertaken, using a Lifeworld approach, initially at an individual level looking at issues such as: spatiality, temporality and relationships. Grounding the analysis in the transcribed words, a reflective Lifeworld approach (Todres et al., 2007) was used to describe and identify effective OT with CYP, across datasets, developing themes throughout the process. Creative analysis endeavoured to capture the range and contrasting metaphors of what has been said.

Data Analysis: The Reflective Lens

Data were gathered and analysed from the researcher's reflexive journal records to identify ethical challenges/resolutions and ensure the reflexive-relational methods used remain congruent with required standards of research ethics and protocols, as well as the overall methodology (Benner, 1994) and aims of the project. Descriptive and interpretive analysis of data from the reflexive-relational perspective (Finlay, 2011) provided important foregrounding information on the researcher/participant component of data gathered, thereby strengthening the trustworthiness for this research.

Phases and methods of Descriptive Data Analysis

Phase 1: Descriptive - In situ

The descriptive analysis began at the point of data gathering. Occupational therapists were asked to describe situations where they felt that the occupational therapy provided had been effective for the child. They were asked to describe situations in as much detail as possible when they felt there had been any breakthrough moments when the therapy had made a difference to the child. In order to assist participants to describe these movements rather than interpret what they thought was going on; they were asked as much detail as possible of what was actually happening at the time (Finlay, 2011). Respondents were specifically asked to describe the environment and behaviour (what was happening in the room and what was being said). It was necessary to commence descriptive analysis in vivo, as required by the reflexive relational approach as the chosen method of co-creating knowledge in an empowered researcher/co-researcher way.

As participants described situations where they felt the occupational therapy had been effective, the researcher actively engaged in the reflexive process (described in the Reflexivity Chapter) in order to clarify understandings from participants and actively utilise the insider researcher position in order to enable rich and detailed descriptions. Responses from participants were at times paraphrased in order to check clarity of communication from their perspective and enable member checking on accuracy (McConnell-Henry et al., 2011) in the moment. The importance of this lies in the fact that post interview member checking is at odds with the methodological approach taken, as it prompts a reflection, rather than a pre-reflective description. Checking in the moment ensures that the ethical responsibility to guarantee that what is being said has been correctly heard and recorded and reinforces the collaborative, co-constructionist endeavour. All interviews were carried out face-to-face which enabled this very early stage of data analysis to consider the embodied experience. At times respondents were moved by the accounts which they provided and such emotional impacts were captured in the researcher's reflexive account. Utilising the reflexive relational approach and techniques, such embodied experiences were acknowledged in situ and also captured via the interviews being recorded and subsequently transcribed.

Phase 2: Descriptive - Overview

The first sweep of the recorded data aimed to obtain an initial overview of the participants' perspectives. This first stage commenced with transcribing the interviews using voice recognition software which required the researcher to listen to and then repeat every word of each interview. This intensive listening process and vocalising of the participants' stories was an unexpectedly

personalising experience. Hearing and speaking of multiple stories of very unwell children who had been helped by occupational therapists was a moving and embodied experience, which became part of the reflexive account.

The reflexive relational approach outlined by (Finlay and Evans, 2009) encourages an awareness of embodied responses during the data collection phase for consideration of interactional dynamics. The concept of embodiment is also encapsulated within Ashworth's Lifeworld approach (2003) to data analysis, which was taken in this study. Consequently, a research diary was kept as a source of data from the outset of the research, continuing throughout the data analysis process and, in particular, after each face-to-face interview, and then during and after the transcription process. These reflexive data were later analysed and is reported on separately in section nine.

Initial drafts of the transcribed interviews were checked for accuracy in content and grammatical format. All eight recorded interviews were transcribed using the same approach with an overview of key themes collected as part of the reflexive process. Initial impressions showed a comprehensive data set which provided numerous descriptions by occupational therapists of the occupational therapy described as being effective for the child.

Phase 3: Descriptive - Phenomenological Descriptive Thematic Analysis

The first phase of descriptive thematic analysis utilised an inductive method to create descriptive codes directly from participant transcriptions. This enabled a phenomenological approach to be taken by bracketing previous knowledge and understanding, and not imposing new or other concepts onto the data. There are tensions between taking a reflexive relational approach and thereby

utilising the insider researcher position as a CYP OT, and the challenges of doing descriptive coding whilst 'holding in abeyance' (Finlay, 2011) previous understanding of occupational theory, practice and models, and assumptions of what participants are talking about.

Initially, transcripts were printed and coded on paper by hand. However it soon became evident that the richness of the interviews was generating a large number of codes which would be more effectively managed and retrieved electronically. Previous consideration had been given to utilising data analysis software and methodological concerns were re-visited as part of the reflexive process (see Chapter 8). It was decided to primarily utilise the data management, retrieval and organisational capacity functions of NVivo and guard against swift or pre-conceptual coding which would undermine the epoche (Heidegger, 1962).

For each individual interview transcript, questions and paraphrasing by the researcher were highlighted and separately coded for future analysis. Transcripts were read and codes created as labels/paraphrases from participant's own words.

NVivo software was utilised in order to manage the volume of data created by the data-gathering process. This was termed phenomenological descriptive coding, and as similar issues were described by participants themes developed from these descriptions resulting in this phase being described as a phenomenological thematic descriptive analysis (PDTA). Verbatim texts were collected under each of these codes for each interview. For many passages there were multiple codes. Codes were developed with each interview as new phenomenon was described. As such, previous

understanding from other coded interviews was bracketed and held in abeyance to allow the natural coding for each interview to emerge. A complete set of codes were then available for each interview, with their associated verbatim text available. All eight interviews were then re-checked to ensure that phenomena which was captured in later transcripts had not been overlooked. The process of coding was therefore more sensitised to the phenomenon and open to data which may have been passed over initially.

Over 500 codes were created relating to the original transcripts and phenomena described by the occupational therapists, each with their own verbatim definition. Whilst frequency of code usage overall has limited value within a phenomenological qualitative analysis, it did however provide an interesting overview to the areas described by the occupational therapists as being relevant to the topic of effective occupational therapy with children and young people. Commonalities and differences were identified across the interviews to look for patterns and structure which then informed the phenomenological descriptive thematic analysis.

Phase 4: Descriptive - Metaphorical Descriptive Analyses.

Transcripts were then re-read, searching in particular for metaphors and descriptions provided by participants. These fell into two categories: those which were directly sought and provided during the interview and others that were drawn out as part of the text, post-interview. These metaphors were then coded using the participant's own wording. All respondents offered a summative metaphor for effective OT.

Phase 5: Descriptive - Lifeworld analysis

Drawing from Ashworth's approach to Lifeworld analysis (Ashworth, 2016), the seven fragments or fractions were given codes/node headings and definitions using NVivo software. The following definitions were given for each of the fragments: Self-hood (identity, agency and having a voice); Sociality (relations to other); Embodiment (feelings about body, gender and emotions); Spatiality (geography places environment and places within which people act/do things); Temporality (past, present and future, time duration and biography); Project (ability to carry out activities are central to life); and Discourse (concepts of language, descriptors and terms used such as educational sociological and ethical terminology).

Phases and Methods of Interpretive Data Analysis

Phase 6: Interpretive - Researcher Reflexive Journal Analysis

Researcher reflexive journal information was transcribed and supervision records over 4 years were analysed thematically, as described in Phase one above, using Nvivo software. Phrases and insights from the analysis are used in the text where appropriate – described in the Reflexivity Chapter.

Phase 7: Interpretive - Interpreting the Lifeworld Analysis: Identifying OT with CYP

Identifying themes across the Lifeworld analysis (Phenomenological Interpretive Analysis) used hermeneutic processes to look at the granular and wider picture. It thus gained in-depth understanding of the phenomenon of effective OT with CYP with MH/LD.

Phase 8: Interpretive - Methods used for interpretive metaphorical Analysis

An artistic metaphorical summary of the phenomenon of effective OT with CYP was completed. The metaphorical descriptive data analysis carried out initially was then interpreted as part of the Lifeworld discourse analysis. Using more artistic approaches, a metaphorical summary of effective OT with CYPS was then created.

Phase 9: Interpretive - Methods used for Reflexive Analysis

Responding to the call by Finlay (2002b) for robust levels of reflexivity in qualitative research, a comprehensive analysis is offered in the Reflexive Chapter.

Phase 10: Interpretive - Contextualising Findings with the Occupational Perspective of Health (OPH)

This final phase was not planned at the outset (that would have been an anathema to the methodological approach taken), but emerged as a potentially valuable interpretive process to consider findings from another perspective. It involved collating the thematic and Lifeworld analysis as new sources of data and cross-referencing this against the OPH. This was done in Nvivo software by creating OPH codes of Doing, Being, Becoming and Belonging and coding the amalgamated thematic and Lifeworld fragment themes against these. The results of this process are presented in Chapter Seven – Contextualising Findings with the OPH.

Summary of Data Analysis & Reporting

Part two of this data analysis section detailed ten phases of data analysis to evidence the chronological way in which the data was iteratively and inductively analysed, – as required by the chosen methodology. It shows the unfolding of the data as it is seen from different perspectives. The reporting of the findings from these ten phases will now be presented in the coming four chapters; Data Analysis – Thematic & Metaphorical: Data Analysis Lifeworld; Contextualising Findings with the OPH; and Reflexivity.

Conclusion

This methods chapter discussed how the methodological decisions to use an interpretive phenomenological approach were translated into the design and implementation. The objectives of this research were set out in the introduction and parameters were set within a population of occupational therapists working in the NHS in England providing occupational therapy assessment and interventions in CYPS.

Part one of this chapter outlined the research design, the data collection preparation phase and fieldwork phase. The importance of these elements was to establish that the research is designed to ensure that the aim and objectives are met. In particular the first objective detailing how the qualitative study will be conducted and the second objective relating to CYPS OT is detailed in the sampling section.

Part two looked at data analysis methods and phases: initially from a descriptive perspective (as defined in the methodology as inevitably

interpreted) and then with an increasingly interpretive exploration of the data. The primary value here is how this research is designed to meet objective three (analysing lived experience and identifying themes (Ashworth, 2003) and objective five (gathering and interpreting metaphors). Objective four was added after the original design, the pre-supposition of its relevance being contrary to the methodological approach taken. It evolved in response to the emerging findings, and the planned method of interpreting the meaning of the lived experience in relation to the OPH is outlined under phase 10 of the analytic process. Data were also created and analysed in relation to the researcher and reported later in Chapter 8.

Chapter Five: Data Analysis: Thematic & Metaphorical

Introduction

The findings in this section relate to the phenomenological descriptive thematic analysis (PDTA) of what was actually happening within the occupational therapy sessions with children. Eight occupational therapists described, in concrete terms what, in their experience, contributed to effective occupational therapy. A worked example of this process will be provided, illustrating how links were made and how large amounts of data were distilled through the descriptive analysis of the interview transcripts.

Five main areas were identified, which will be detailed here and illustrated with quotes taken from transcriptions of interviews. The presentation has been ordered to illustrate the way that the process of therapy unravels, each encounter provoking a bespoke, personalised response from the OT. Starting with the child and their presenting issues, the consistent starting point of the OTs was to adopt a child/CYP-centred approach to engagement in therapy and acceptance of the child for who they are. Secondly, the OTs' approach, beliefs and values will be detailed, seeking to build a trusting, non-judgemental approach, underpinned by the importance of never giving up, even when engagement or therapy is personally challenging for the OT. Thirdly, the use of time to structure therapy, and allow the child to utilise the session however they wish and how this evolves throughout the therapy, will be discussed. Fourthly, the OT practice itself will be examined with dominant themes emerging inductively from the data of: environment; meaningful activities; grading; positive risk taking; OT as an embodied therapy; and outcomes, themes related to the child and the OTs' views.

The fifth section of this chapter will focus on the thematic analysis of the metaphors of effective occupational therapy, which all participants shared. Themes of flow, growth, creativity and containment, and the emotions related to the phenomenon, will be provided.

Worked Example

This section details the analytical process of how participant interviews were analysed from the outset, using Diane's interview as an example, and distilled into codes and themes. Figure 1 provides a summative reminder of phases one to five of descriptive analysis and Figure 2 shows the interpreted analysis steps six to ten. A further five illustrations detail the process of analysis and succinctly capture the journey from transcript to themes, using Diane's interview as an exemplar of the process used for all eight interviews.

The full transcript of Diane's interview referred to in the worked example is provided in Appendix 32. Phases of descriptive analysis (1-5) commenced in situ (phase one) and are captured in the recorded paraphrasing and follow up questions shown in Diane's transcript. The second, overview phase, is enabled through reading the whole transcript through and by taking field notes post interview and post transcribing, which were later coded as part of Phase 6, which included Nvivo data analysis of the research journal and supervision records, using the same methodology outlined here.

The process for Phases 3 and 4 are best understood by taking the excerpt related to Diane's comments about the metaphor of the roller coaster, with its highs and lows, shown in Figure 3 below. This NVIVO screen capture shows how phases 1-7 can be seen, with the central panel showing the transcript text, metaphor question, response and related inductive codes used of 'roller coaster' and a further sub-code of 'lows'. Coloured coding stripes in the right hand panel provide an overview of the summative coding of this excerpt. The left hand panel entitled 'nodes' (codes), provides a sense of other metaphors

offered by participants, each used verbatim to label, or code, the quotes they refer to.

The process of creating and then modifying codes is shown in Figure 4: an annotated NVIVO screenshot. It shows eight sources (participant transcripts) which have over four thousand references, or identified quotes, date of code creation and modification, required by the increasingly interpretive analytic processes (see Figure 2). Diane's metaphor of effective OT being like a rollercoaster also shows the sub-code of 'lows', its date of creation and when it was modified. In this way a transparent audit process is available, which can track text, from its final coding back to its roots in the transcript. The coder can define each code at the point of its creation, and this detail is available for external review, by right clicking on the code/node to view its properties.

Having coded Diane's entire interview, Figure 5 of an NVIVO screenshot shows how four thousand words (of Diane's nine thousand word interview transcript), was distilled into approximately fifty codes.

Figure 6 provides further detail of the PDTA codes (see Figure 1, Phase 3) which evolved from Diane's interview and the frequency of use. For example, there were sixteen references to the code 'OT never gives up', similarly for offering 'environmental choices', followed closely by references to the OT approach, beliefs and values'.

The final illustration in Figure 7 provides a comparative thematic and metaphorical data analysis (effectively showing Phase 3 PDTA), by participant. By comparison with other participants, Diane's emphasis on the importance of the 'OT never giving up' is evident in the large green section, which although

present in all other interviews to a lesser extent, was accentuated by Diane. Similarly, Di said more about the provision of environmental choices (cream coloured section) in effective occupational therapy.

Whilst these images provide a worked example of the analytical process, it is important to note that the interpretive phenomenological methodology is not a reductionist endeavour. As well as providing a valuable way of managing large amounts of qualitative data (coding, storage and retrieval), Nvivo software automatically counts frequencies of coding. A caveat of caution is suggested in looking too closely at these numeric references of an element of the phenomenon. The analytical researcher is required to be disciplined and to maintain an acute awareness of the underpinning ontological, philosophical and methodological approach of the specific study: to be cautious in attributing meaning, or making inferences based on the quantitative information automatically generated by Nvivo. The supervisory processes and reflexive practice/journal (see Chapter 8), enabled such rigour to be applied to the data analysis in this research.

The hermeneutic process was an important counterbalance to the drilling down into the data and then crucially, the stepping back: to purvey the sense of what was emerging from the individual transcriptions and then across the whole dataset and essentially, how the strands of understanding weave together to create an impression of the phenomenon of effective occupational therapy.

Figure 1: Descriptive Analysis Phases 1-5

Diagram Showing Phases and Methods of Descriptive Analysis

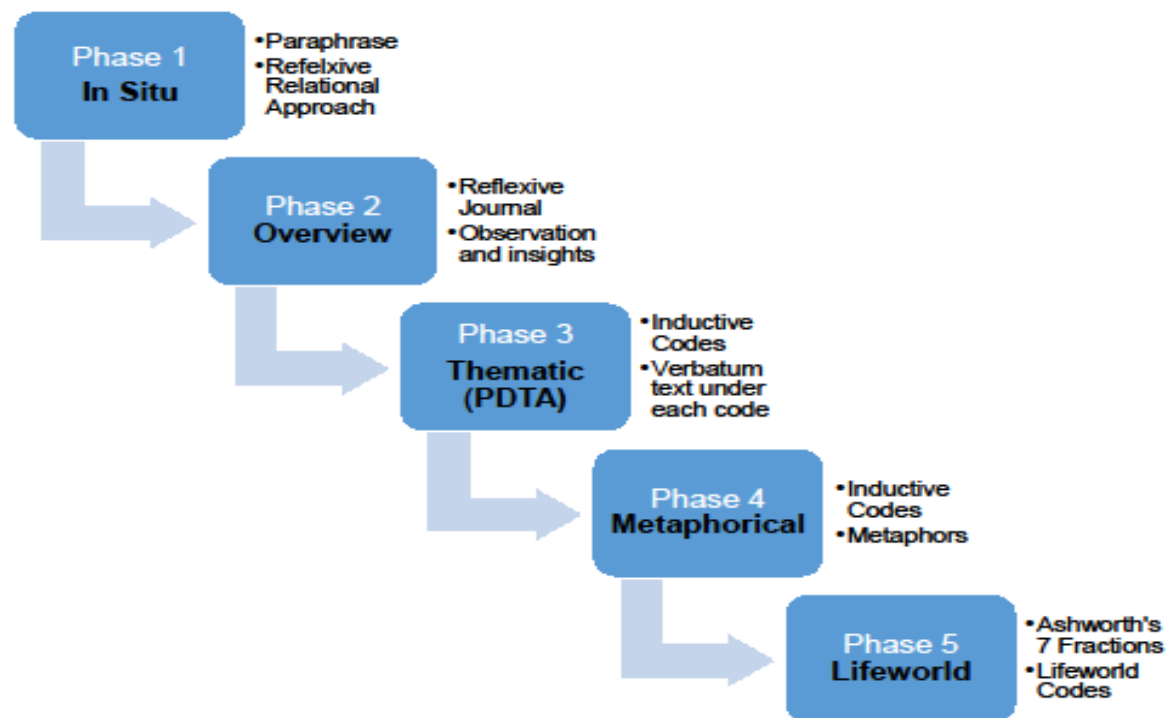


Figure 2: Interpretive Analysis Phases 6-10

Diagram Showing Phases and Methods of Interpretive Analysis

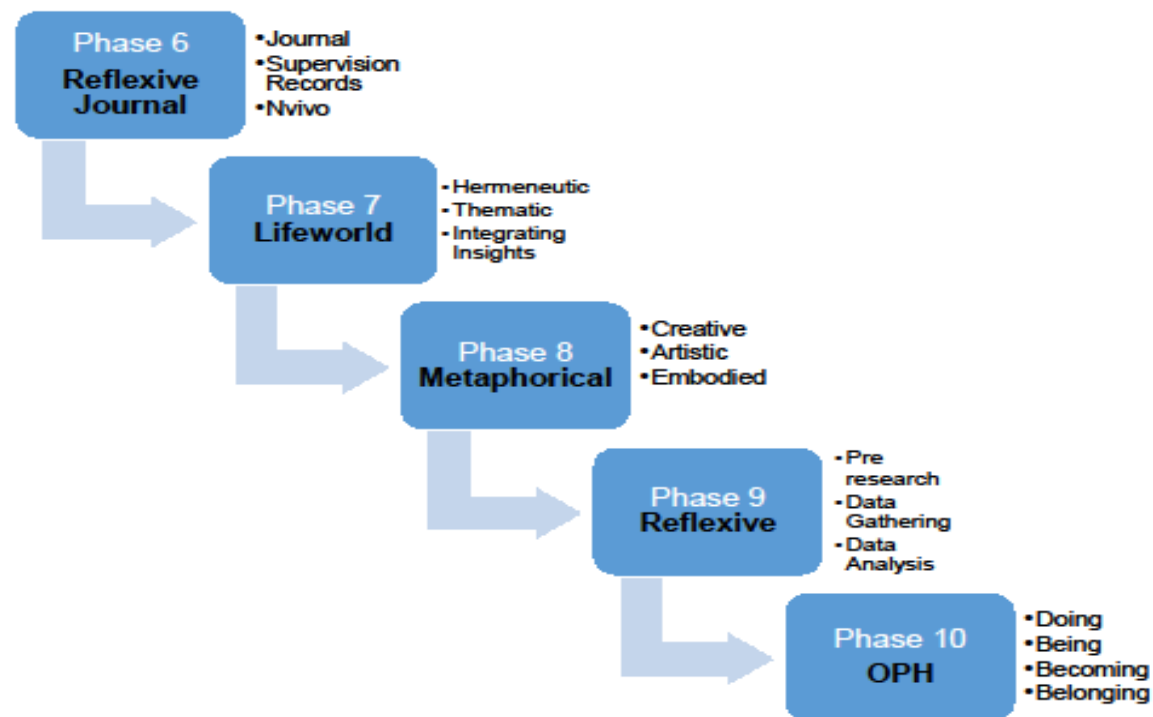


Figure 3: Diane's Rollercoaster Metaphor - from Transcript to Coding

Phase 1 In Situ
MQ Reflexive
Relational Approach
Co-creating

Phase 2 Overview
Diane's Interview
Transcript

Phase 4 Metaphorical
Descriptive Analysis
Di's metaphor of a
Rollercoaster

Level 4
PDTA
Metaphor
Quote
&
Sub-code
'Rollercoaster'

Level 5
Rollercoaster 'Lows'
Quote from transcript
Sub-code
'Lows' coding stripe

Phase 3, 4, 5, 7
Analyses
Shows: PDTA,
Metaphorical and
Lifeworld Codes
(different coloured
stripes).

At some stage I interested to know if you fell like there is a metaphor or a picture that might sum up, when OT is really effective, you know.. that's like what.. Does it illicit a thought or a picture or a metaphor for you?

Di I keep thinking of a rollercoaster, because that's how I feel about working with kids, is that when you actually connect with them and you can see the change, it's absolutely amazing. It's just, the best feeling ever, when you make that connection and you can see progress and development and you can see the children are kind of setting off down a path that is better for them, that they have chosen and they have had a part in. That's amazing. And that's the highlight but then the low bit is kind of really quite horrific in managing the kind of dynamics around working with children and the emotional processes, the risks, the legal system and around kids. The fact that we are working in, it needs to be said, were working in times where people aren't investing in children's so cross, that when we have all the, you know, developmental research, theory about interventions with children at a young early age and the children if we intervene early with families, there, risk and resilience theory, why aren't we investing in children? we

Summary
Reference
Text
LW OT relationship with supervisor or others
LW Occupational Therapists Self-hood
Supervision of OT
Question and paraphrasing responses
LW OT Speciality
LW Temporality OT
surrounded by a container
LW Discourse of OT
LW Temporality Child
Freedom & Historicity
LW Ward or other place Speciality
LW OT Embodiment
LW Occ therapists project
Coding Density
Lows

Figure 4: Diane's Rollercoaster metaphor: The Process of Code Creation, Modification and Phases of Analysis

OT Lived Experience Nvivo 4 Aug 15.nvp - NVivo

Phase 2
8 Interview Transcripts

Phase 1, 3, 4, 5
4550 Quotes Coded

Phase 4
PDTA Metaphor Code Created 4/8/15

Phase 7
PDTA Metaphor Code Modified 4/11/15
Transferred under: 'Lifeworld/Discourse'
Originally a level 1 parent node

Level 1
Parent Node

Level 2
Child Node

Level 3
(Child Code)
PDTA Metaphor

Level 4
PDTA Metaphor Sub-code Rollercoaster

Level 5 Rollercoaster Sub-codes: 'Lows' 'Surrounded by a container'

Rollercoaster codes created 16/8/15 (Phase 4)

Rollercoaster codes modified 24/10/15 (Phase 7)

Name	Sources	References	Created On	Created By	Modified On	Modified By
Lifeworld Fragments	8	4550	04/08/2015 23:25	MQ	28/03/2016 17:27	MQ
Discourse	8	843	04/08/2015 21:11	MQ	17/09/2015 14:35	MQ
LW Discourse of OT	7	42	17/09/2015 14:34	MQ	04/11/2015 13:51	MQ
LW Discourse of the CYP	3	4	17/09/2015 14:35	MQ	04/11/2015 13:52	MQ
LW Discourse of researcher MQ	2	5	17/09/2015 14:34	MQ	04/11/2015 13:51	MQ
PDTA Metaphor	8	118	04/08/2015 21:12	MQ	04/11/2015 14:59	MQ
Canal, opening locks	1	2	01/09/2015 22:36	MQ	27/10/2015 00:25	MQ
CYP as Leader	1	8	25/08/2015 11:31	MQ	25/08/2015 13:57	MQ
Enabling eg. Walking Free	1	3	02/09/2015 00:23	MQ	27/10/2015 00:25	MQ
Getting the measure of someone	1	1	05/08/2015 22:37	MQ	11/08/2015 18:03	MQ
Getting to the Nitty Gritty	1	1	05/08/2015 22:38	MQ	11/08/2015 18:03	MQ
Going round the houses	1	4	08/08/2015 17:54	MQ	11/08/2015 18:03	MQ
1 Ducking and Diving	1	1	08/08/2015 17:55	MQ	11/08/2015 18:03	MQ
2 Steer their own way	0	0	08/08/2015 17:56	MQ	11/08/2015 18:03	MQ
3 Bend over backwards	1	1	08/08/2015 18:00	MQ	11/08/2015 18:03	MQ
Jigsaw Puzzle sphere	2	3	24/08/2015 23:16	MQ	27/10/2015 00:25	MQ
Jump hurdles	1	6	05/08/2015 22:13	MQ	11/08/2015 18:03	MQ
Jumping	1	5	08/08/2015 16:59	MQ	11/08/2015 18:03	MQ
Sixes and Sevens	0	0	08/08/2015 17:55	MQ	11/08/2015 18:03	MQ
Metaphors in script	5	34	11/08/2015 11:10	MQ	17/09/2015 21:52	MQ
Onion	1	3	04/08/2015 21:28	MQ	25/10/2015 16:03	MQ
physios will teach you to walk but OT's will teach you t	1	1	01/09/2015 00:29	MQ	26/10/2015 23:28	MQ
Quick sand	1	2	05/08/2015 22:11	MQ	11/08/2015 18:03	MQ
Roller Coaster	2	6	16/08/2015 23:41	MQ	24/10/2015 14:42	MQ
Lows	1	2	16/08/2015 23:43	MQ	24/10/2015 15:12	MQ
surrounded by a container	2	3	16/08/2015 23:46	MQ	27/10/2015 00:24	MQ
Student	3	3	14/08/2015 16:04	MQ	21/09/2015 16:29	MQ
Sunsh	13	13		MQ	17/09/2015 21:24	MQ
Turnin	5	5		MQ		MQ

Figure 5: Diane's Interview: 4000 Words into 50 Codes

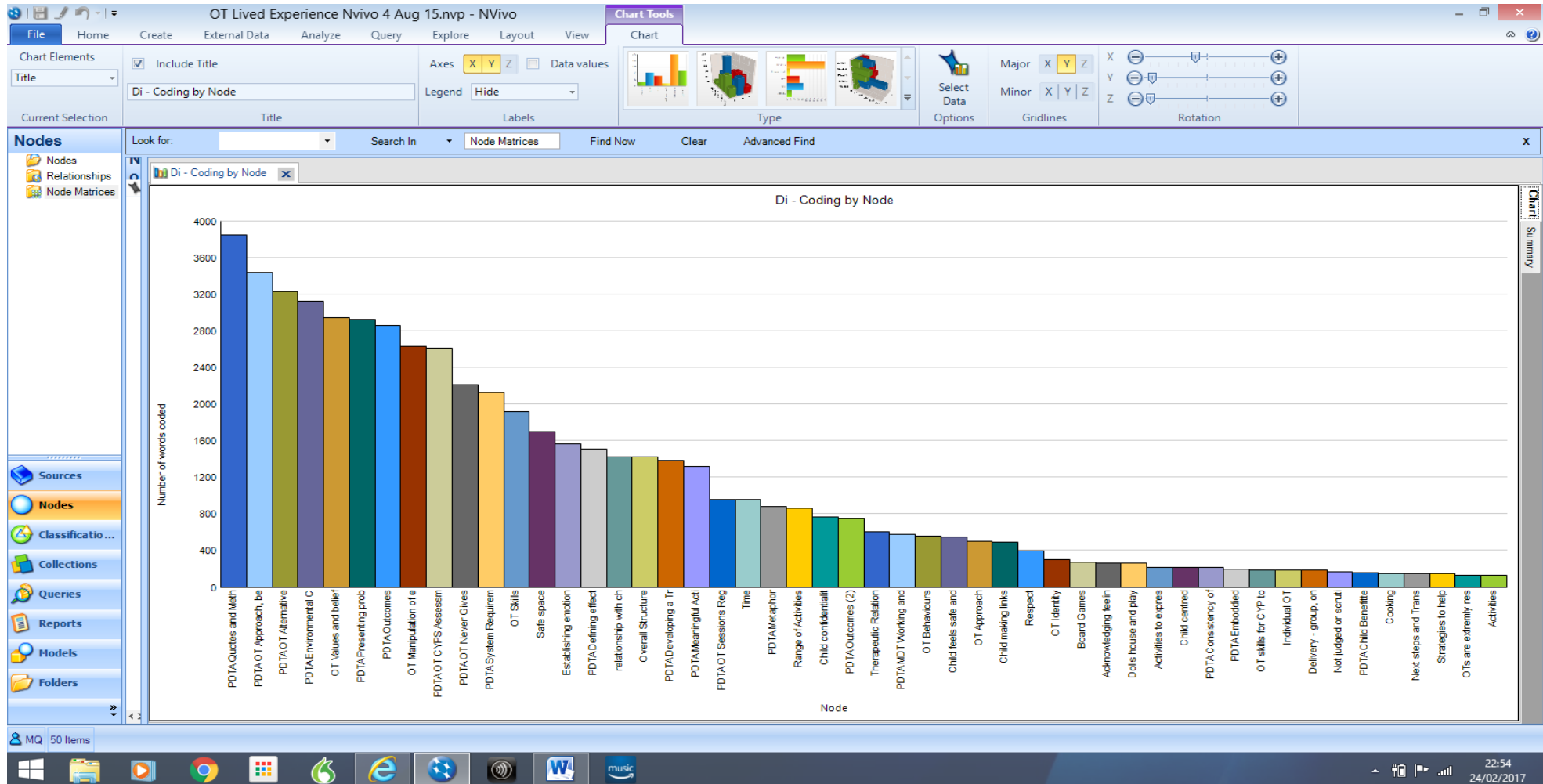


Figure 6: Diane's Coding References Count for all PDTA Codes

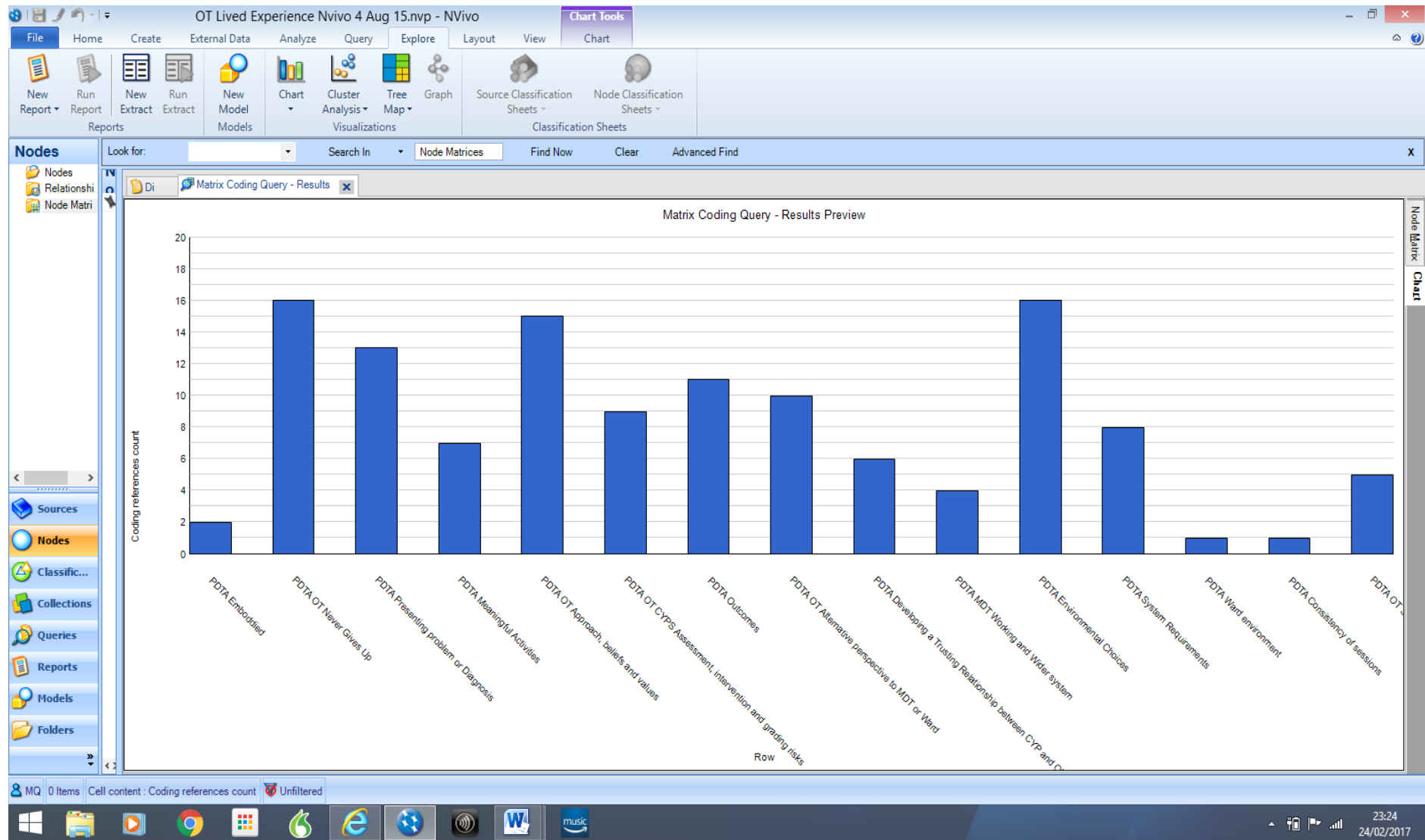
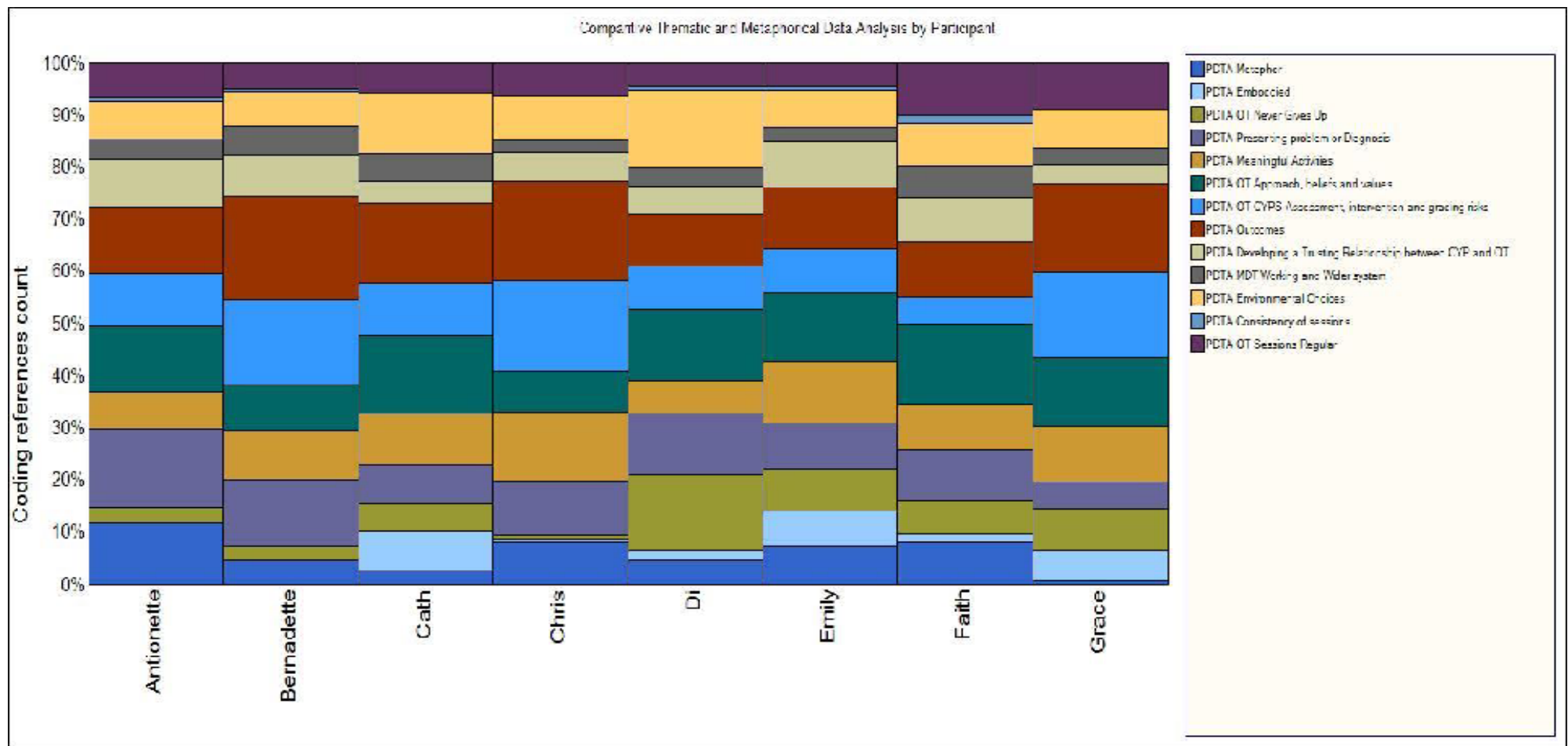


Figure 7: Comparative Thematic and Metaphorical Data Analysis by Participant



Child-Centredness

Under this thematic category, five aspects are identified: understanding the child's problem; their motivation; what child-centredness means to respondents; the importance of acceptance of the child; and how the culmination of these elements results in child-centred engagement practice for OTs.

Understanding the Child's Problem

Specialist CYPS services see children who have multifaceted needs, the complexity of the main task is to unpick the multiplicity of issues to establish the core concern(s). The majority of participants described their role, as part of the multi-disciplinary team, in formulation and differential diagnosis (Appendix 9: Quote 1 & 2 (Q1, Q2)), even though this is unreported in the literature.

One participant's beliefs particularly were echoed by others, as: empathy, caring, compassion, fairness, privacy, dignity, being gentle, and not being judged or scrutinised, but instead seeing children's potential.

Understanding the Child's Motivation

All participants had worked with CYP with autism, and examples of how occupational therapy was felt to be effective were that it offered an alternative understanding of a young boy's behaviour (Appendix 9: Q3, Q4).

The staff patient ratio on in-patient wards is a minimum of 2:1, and can be 4/5:1 for some very disturbed children, resulting in having circa thirty nursing staff, plus the MDT. This raises issues of privacy and dignity for the CYP and helps to contextualise the example given of feeling scrutinised, not as a symptom of paranoia but a likely occurrence, and OT providing space and privacy.

Understanding Child-centredness, Engagement & Acceptance

Child-centredness was universally mentioned by participants as core to effective occupational therapy (Appendix 9: Q5, Q6, Q7). Emily's described a commonly held belief of OTs: that children need to feel safe and be accepted for who they are and how they present emotionally (App 9: Q8, Q9). Cath reinforced seeing the child as expert, where her focus was to empower CYP. Effective occupational therapy was described as doing everything possible to engage children with MH/LD issues, within this child-centred approach.

Summary

Under the PDTA thematic category of child-centredness, five elements have been illustrated: understanding the child's problem; their motivation; what child-centredness means to respondents; the importance of acceptance of the child and how the culmination of these elements results in child-centred engagement practice for OTs. The next section will explore therapeutic engagement in practice and the beliefs and values which underpin many of the descriptions provided by participants.

OT Approach, Beliefs and Values

This section explores the thematic (PDTA) category relating to the approaches, beliefs and values of OT. Sequentially, these are: the development of a trusting relationship and engaging the CYP in OT; establishing the parameters within which CYP can lead sessions; the flexibility and determination of the approach required of the OT; and core beliefs about professionalism and providing an alternative perspective to the dominant medical paradigm.

Developing a Trusting Relationship & Engaging the Child

Establishing a rapport and a therapeutic relationship with the young person is core to effective occupational therapy (App 9: Q10), helped by getting on their level both emotionally and physically. Echoing Antoinette (App 9: Q11) and others, Chris summarised the centrality of a meaningful relationship:

“It's the relationship that you have with the young person first and foremost. If it's consistent and meaningful and your truthful and you keep your promises as well as is reasonable and there is a professionalism about that relationship then I think if you provide nothing else to that young person that is the most important thing that you can actually provide that the therapeutic use of self in a professional way, but, but that meaningful relationship.”

Child as Leader and Safety Rules

Emily described the safety rules commonly used in OT (App 9: Q12), including safeguarding and confidentiality as well as physical safety. Meanwhile, Faith emphasised child leadership as key (App 9: Q13), especially in establishing a sense of control from the beginning.

Antoinette stressed the importance of trust and consistency (App 9: Q14), reinforced by Bernadette who highlighted consistency in communication as vital (App 9: Q15).

Flexibility

Behind an adaptable, flexible approach lies the underlying aspect of effective occupational therapy, of being able to change track (App 9: Q16).

Diane spoke of the uniqueness of OTs to adapt by the moment:

“I think what OT has, that I think is really special, is the ability to kind of adapt almost by the moment to what a child is doing, so that they can succeed using the environment and the activities.”

OT Never Gives Up

The determination of OTs to not give up was a much spoken-about aspect of therapy (App 9: Q17), showing tenacity and emotional resilience. Participants shared a range of feelings about the relief and anxiety of working with CYP, battling on their behalf as well as dreading sessions.

Interestingly, OTs were reticent to be critical of any staff, but differences in approach were articulated by most participants. Bernadette acknowledged here how ward staff have a very different experience of the child:

“I don't mean to discredit staff. The ward staff do what they can....but I think just, it's not giving up on people. Not saying the other staff do at all, I think, it's that I, I really appreciate the staff on the ward must find it really difficult, they have to deal with the crisis. They're fire-fighting, the problem behaviours”.

Professional Boundaries

Emily spoke of her frustration (App 9: Q18) with nursing ward staff maintaining professional boundaries and missed opportunities to consider the motive behind intrusive, personal questions from children.

OT Alternative Perspective: Beyond Medication and Diagnosis

Bernadette described the role occupational therapy served within the service was to provide an alternative, rehabilitation perspective (App 9: Q19).

Cath, meanwhile, described it as empowerment:

“So my OT perspective would be...to re-empower the client as soon as possible and not to have any dependence”.

Antoinette built on this point (App 9: Q20), talking of the value the team see in OT, beyond the medication and understanding of diagnosis, and in the real world. However, several respondents spoke of disagreeing with the medical diagnosis guiding treatment (App 9: Q21).

Summary

This section explored OT approaches, beliefs and values relating to engaging the CYP in a trusting relationship, providing parameters within which CYP can lead sessions, adopting a flexible, determined and professional stance to providing OT, and an alternative perspective to a medicalised view of children’s problems and their resolution.

Time

Building on the core belief in child-centredness outlined earlier, the thematic analysis of time highlighted the following key areas of: consistency (of sessions and of OT approach); regularity of sessions; transitional points (in development and moving on); and CYP's use of time (in and out of OT sessions). This is presented here in terms of the beginning, middle and end phase of OT.

Beginning Phase of Occupational Therapy

Consistency of sessions

The importance of consistent occupational therapy sessions from the outset was commonly described (App 9: Q22), with the theme of using a determined approach echoed by Diane

“I think the principles of engagement are still the same, you know, I would still try and develop consistency and a rapport and certainly be at their level and their developmental level.”

Regularity of Sessions

All respondents spoke about providing regular sessions, commonly an hour long with weekly intervals. Antoinette talked about the incremental progress of ‘after a while’, following weekly sessions over nine months, as demonstrating OT persistence (Appendix 9: Q23).

Transitional Points: Developmental Stages

Grace's contribution (Appendix 9: Q24) also highlighted the therapists' evaluation of the importance of regularity and rehearsal in terms of the important developmental stages for the child. Whilst Grace was able to stray

beyond the commissioned service, Diane raised her concerns about therapists not having enough quality time and the importance, shown in research, of working at the child's pace (Appendix 9: Q25)

Faith also talked about the value of not hurrying an adolescent girl (Appendix 9: Q26) and how this is shown in her improved functioning skills.

Finally, a common rule of OT sessions was starting and finishing on time, described here as a challenge for a 12-year old boy:

“He never wanted to end. This was a lovely experience. Then he really struggled with ending on time. We did a lot about the importance of ending and reassuring him that next week would happen, it wasn't a one-off experience.”

Middle Phase of Occupational Therapy

Consistent Approach of OT

The importance of consistency throughout the time in occupational therapy was echoed by all participants:

“So I stuck to my word it's all about that trust and being consistent.”

Faith went on to talk about the importance of coping mechanisms in order to have consistent presentation across sessions (Appendix 9: Q27). The altruistic sense of how personally challenging some of these OT sessions can be for the therapist is also apparent in this observation from Bernadette which alludes to the sense of time in therapy sessions feeling distorted:

“...before, it would have felt like a long period of...probably not long when you're filming it ...but it is when you're sitting there, it can feel like quite a long-time...(laughing)”.

Child's Pace in OT

The ultimate control and consent of the CYP and the importance of going at the child's pace is unequivocally described by Emily:

"And then we stop when they want to stop. So, that's made really clear that every session. If you feel like we've done enough, if you have had enough today, if it's a bit heavy going, or if they're not really interested in what we're talking about, we just stop."

Emily also described progress over multiple sessions:

"So we started working and every session he asked to be in the kitchen and that was obviously the place he felt comfortable. Gradually, over the weeks, he started to open up whilst he was cooking, about things, memories that it brought back."

Child's Time outside OT

Understanding the CYP's transition from OT to the ward environment is described here by Faith:

"...she needed time to process, because processing skills are so, so slow, she needed time to come away from that really empowering session to then come into an authority, rules-led (ward) environment."

Faith and Grace both used the language of time, difficult times and unstructured times, providing insight into the passage of time from the children's perspective:

"So the nursing staff adapted that, gave her time out in the evening, because evening time was a most difficult time, again that was when the trauma happened.."

"She didn't cope very well at all, in those times when there was nothing on the timetable or she found it very difficult to find things for herself to do or to structure her day."

Bernadette raised the use of OT sessions as 'timeout', which, whilst being therapeutically valuable, contrasted the intense ward environment (Appendix 9: Q28).

Ending Phase of Occupational Therapy

Transitional Points: Moving on

Cath noted the importance of transitional times for CYP (Appendix 9: Q29) of a young man ready to move on from occupational therapy having acquired verbal skills. Similarly, Faith pointed towards the future for her client with transition to specialist adult MH/LD services, the constraints of commissioned periods of intervention and a sense of reserved hope, contingent on a slow pace (Appendix 9: Q30).

Cath and others spoke about transitions and how when occupational therapy came to a close, it was often marked symbolically with an activity (Appendix 9: Q31).

Summary

This phenomenological descriptive thematic analysis (PDTA) of time has identified child-centredness underpinning how time is used in the beginning, middle and end phases of occupational therapy. The key areas of consistency (of sessions and of OT approach), regularity of sessions; transitional points (in development and moving on), and CYP's use of time (in and out of OT sessions) have been illustrated with examples from the lived experience of OTs working with CYP with MH/LD.

OT CYPS Assessment & Intervention

The thematic analysis highlighted many aspects of the OTs' assessment and intervention which emerged as important aspects of effective OT in the lived experience of those who participated. This section will draw upon salient quotes which illustrate significant levels of commonalities across respondents, despite robust methodological tools to seek out and capture differences and polarised viewpoints. In layman's terms, they were singing from the same hymn sheet, though such music has not been written specifically for CYPS OT. Key active ingredients identified were: environmental choices; meaningful activities; grading activity; positive risk taking; and embodied practice. Each are detailed within this section.

Environmental Choices

OTs spoke about the way in which they work within environments and manipulate them in order to maximise the therapeutic choices and opportunities for the child in terms of therapy, including the ward environment and the impact of wider system requirements. CYP are seen by OTs in a wide range of places, including: art rooms, bedrooms, café, gym, OT therapy rooms, play rooms, recreation areas, the kitchen, the child's own home and out into the community.

Like many others, Antionette described initially starting in a consistent place and then straying further:

“More and more consistently in the same environment at the start. And then we started to work and go out into the community”.

Grading Environments

Antoinette echoed a shared frustration that what OTs appear to be doing with children seems very straightforward, when in fact they are using micro levels of environmental grading in order to encourage the CYP to feel comfortable and engage more (Appendix 9: Q32). Bernadette also described the importance of their limited but valued OT space (Appendix 9: Q33).

Child-Centred not System-Centred

Antoinette talked about being centred on the person instead of the system; working around the ward culture:

“It is quite hard, but most of the time it is doable...It's easy for a system to just be kind of “this is what we do” it's useful to have a few people in there that encourage the system to do things a bit differently and finding other ways”.

Diane identified the CYP's need for space to talk prior to/without an official disclosure and that even safeguarding systems designed to support the child may need to change. Currently, children have a somewhat polarised option of saying nothing or having to say everything, without specialist OT/professional support to enable them to work through the complexities, consequences and fears around disclosure, or therapeutic mitigations/interventions which could enable greater therapeutic outcomes for them (Appendix 9: Q34).

Ward Environment

Bernadette offered a glimpse of ward life in some in-patient CYP units, with challenges for OT to influence how risk is managed:

“I think the difficulty is around, and it is partly you know, we're not there, we're not staff on the ward that are getting punched and strangled on a regular basis and it's that risk-taking on the ward that is a much harder risk to sort of manage or for us to have as much impact on and change”.

Faith and Grace (Appendix 9: Q35) described the importance of keeping planned OT sessions, and how their young people managed to keep out of seclusion and restraint with the support of OT:

“It didn't always happen, that depends on her and her mental health. A lot of the time she was in seclusion. Now I still keep those three sessions in and she's attending most of those now.”

Meaningful Activities

Meaningful activities were also seen as a key area of effective occupational therapy from OTs' descriptions. This included related themes of having a balance of occupations, the mode of delivery and the range of activities or occupations offered.

Balance of Occupations

Chris described the need for balance:

“the other thing as well is ensuring that whatever you do with your opportunity to work with the young person, you look at the balance of occupational roles”.

Grace highlighted the fun element:

“I feel like the leisure side of things are often forgotten about and giving children a play opportunity and fun opportunities and helping them still have the child like experiences that they should be having outside”.

Mode of Delivery

The majority of sessions were one-to-one, though Cath talked about the move to family work as a progression from this (Appendix 9: Q36). The place of group work was spoken about by Chris, with a determination that it should not replace individual time for children (Appendix 9: Q37). So both family and group work was seen to be secondary to the individual occupational therapy sessions.

Range of Activities

Figure 8 below offers a visual presentation of the types and range of activities carried out in occupational therapy sessions. All participants used cookery and time in the kitchen, though the range of activities which happened under this heading varied considerably from tea and a chat to regressive play, baking cakes that grandma used to make, preparing sushi without scrutiny, making curry from jars to making from scratch and making shared communal biscuits. This is outlined in detail in the discussion chapter.

Figure 8: Activities Wordle



Grading activity

One of the required skills identified by many of the participants was that of grading (Appendix 9: Q38), with Chris's example providing good insight into its complexity.

The global assessment

Emily highlighted that global assessment occurred during occupational therapy:

"I think OTs combine it with lots of other different things. So we're constantly looking at his numeracy skills, literary skills, his motor skills, his social skills, his communication skills, the list could just go on and on. So I think I see both, with him we were skilling him up to be more independent. We were doing sessions, we were pushing him each week with challenges around what he can cook but within that we were grading it, making it safe for him."

Positive risk-taking in OT vs. what can go wrong?

Positive risk-taking in OT, as an aspect of grading, was described by the majority of participants as being effective for the CYP, as it aimed to increase independence. This is juxtaposed in the example (Appendix 9: Q39), provided with the dominant risk management perspective on the ward, which judges what can go wrong.

Rehabilitative Approach

The graded risk-taking which happens in OT sessions may be the initial learning of rehabilitative skills for a greater rehabilitative journey where skills

are learnt to address deficits which are discovered when pushing beyond the usual parameters.

Embodied

Whilst all examples given were describing one-to-one sessions where the OT and CYP shared the same physical space as they engaged in activities, the physical nature of doing occupational therapy with young people was mainly reported in relation to getting down to, or onto, the child level:

“...so you have to overcome that when you work with kids, get onto their level not just with the play but with the emotions and that therapeutic friendship, if you like.”

Using touch for reassurance

Emily, unlike other participants, spoke of a reassuring touch:

“... I just laid my hand on his shoulder and I said, it's okay, It was an accident you not going to get wrong and just gave lots of reassurance, I can see your upset and it's okay to be upset and it was an awful thing that just happened and he held it together for ...not very long and then he just left the room.”

This is a stark contrast to a boy who previously needed an entourage of nurses to manage his aggression, while this upset boy accepted a physical reassuring touch. The lack of discussion about physical touch was surprising and raised a query about how children on in-patient services, away from home, get physical contact. Most physical contact outside of OT was described in terms of managing violence and aggression and the absence of the opposite needs for warm and physical comfort, apart from this one example, is worthy of note.

Outcomes

Discussion around effective OT highlighted a broad spectrum of outcomes valued by the OT such as: meeting the OT aims and objectives related to school, peer relations, activities of daily living, independent living skills, building confidence, self-esteem, emotional literacy, sensory processing skills, monitoring mental health and sex education. These are illustrated in the following examples.

OT Therapeutic aims and objectives

Emily and Bernie noted the role of sensory work in effective OT (Appendix 9: Q40) as well as the fluidity with which areas needing development are incorporated into OT. Tracking presentation within everyday tasks was also seen as a key:

“So a lot of the time, with OT in mental health is more about tracking their presentation every week and noticing the subtle changes. Picking up what might be problems more over time. You have the consistency when you can...seeing someone every week...you could compare in more objective ways. So OT is using a slightly different way.”

Inpatient units with growing adolescents have an important role to play in assisting the young person to understand sex education and healthy relationships. Emily described this as a core part of personal activities of daily living within occupational therapy (Appendix 9: Q41), and the sensitivity used to support people.

Child Outcomes

Grace identified the need to have child-valued OT:

"I think every session with her was effective and certainly definitely during every session, you can see that her mood would lift and there was a feeling that she liked to have other people involved in what she was doing".

Emily noted one boy's mood in the session:

"He went to wash a bowl up and we've got a drinking water tap as well as a normal water tap. So the water comes up as much higher pressure and he pushed the button and it went into the bowl. But then it came out again like a fountain. And he was mesmerised by this fountain and they started playing with the fountain, quite regressive, quite early developmental play. I just stood next to him and I didn't say anything, just allowed him to do and watched him enjoying it."

Further evidence of young people valuing OT is described here by Faith:

"that girl actually I'm not sure if you're aware of this but, wrote to me several months after she left the hospital and she said it had been a very helpful time and that she had actually being able to work through feelings in a way that she hadn't realised that the time. And she thanked me for that ... even though it been very difficult because we did a lot of artwork which was her way of expressing things non-directively."

There are many examples of the child seeking assistance and putting things into practice:

"I think for me, the main times... it was actually her involvement in it... she had the motivation to want to move on, but she was actively seeking the support and assistance. But also she had, and it's not very often this happens, it's her ability to say when staff wants to do things for her she would say "no! Let me do this myself".

Occupational therapists described a range of outcomes as a result of occupational therapy, including establishing boundaries, child development, evidence of the child making links, the child feeling in control and empowered and then putting into practice what they have learnt (Appendix 9: Q42).

Summary

The thematic analysis highlighted key active ingredients of effective OT assessment and intervention as: environmental choices; meaningful activities; grading activity; positive risk taking; embodied practice and outcomes. This section used salient quotes to illuminate surprising levels of coherence across respondents, given the paucity of published work on CYPS OT practice. Whilst it is possible to speculate on shared learning through networking, post-graduate courses, undergraduate OT education, CPD undertaken, OT leadership and supervision practices, it was not part of the aim or design of this study to investigate the genesis of practice influencers, with the question of implications for future research to be identified later in the Recommendations Chapter.

Nevertheless, the overriding message is one of coherence. From the grading of environment, activities and exposure to positive risk taking, along with measuring outcomes in terms of the impact on the child's life, there are strong messages which will be taken forward into future analysis, as this becomes more interpreted and synthesised and as new insights are gained by looking at the phenomenon from different angles.

Metaphorical Analysis

The following analysis addresses the fifth objective of this research to gather metaphors of effective OT and offer an interpreted metaphorical explication of it. OTs were given the option to summarise their descriptions of effective OT using a few words, a metaphor or any other artistic means of expressing themselves. All participants offered a metaphor, some spontaneously following and emerging from conversation and others after simple prompts such as “effective OT, that’s like what?”

The same PDTA process was applied to the metaphors as part of the transcripts. From this analysis, themes of flow, growth, creativity, containment and emotions related to the phenomenon emerged, evidence of which will be provided.

Obstructions and Flow

Navigating systems, anticipating barriers within the systems around children, adapting around structures, jumping hurdles and going round the houses were strong themes for two of the respondents. This is succinctly outlined below my Cath:

“Opening Canal Locks”

Cath drew on an image familiar to OTs, of CYPS OT using psychoeducational adaptation, like using a bath board, to facilitate independence. (Appendix 9: Q43), Cath went on to extend into the idea of OT as facilitating ease and flow.

C: "Yes, yes like a canal. And the locks you know you open the locks, your grateful and for little while you go downstream or upstream, and then another lock has to be opened or closed. Because that is what it feels like. Because there is good flow in between but sometimes locks are really hard to loosen off...sometimes you got to ask other people to help out. And that's good and working within the MDT we have a good understanding of what we do.... If you're only going to be looking at the barriers, or the locks, you would just stay static, wouldn't you, and I think that's helpful for the child and further system... The assessment was the lock gates I was so curious why this boy was presenting how he was. So we had the cognitive stuff and I wanted to unlock that, I wanted to see what that was about. I wanted to see why is he so emotionally reactive? And the pieces together started to make the picture".

Notable too is the final allusion to a jigsaw, which resonates with other metaphors used.

Learning & Growth

The following two metaphors describe the element of effective occupational therapy centred on learning, growing and enabling natural potential to come forth.

"Turning on the Lights for Them to Sparkle": Faith's metaphor

"...That independence is a core part of being an OT, you just... you're turning on the fairy lights so that they are blinkering, they can see, they are the tree. They are the framework, and we are just adding little bits of light as we're turning them on... They're the tree and we are the people that are turning the lights on for them to then sparkle... It's about ... how that young person takes more responsibility themselves... I think she's probably going to need a lot more, slower intervention... to bring on more of those sparkle moments she needs more lights switching on. It needs to be at her pace, as they (the team) were going quicker and she can't cope... I do think there is hope that she will switch on more, as long as it is done in a slow way. But then we have all those other demands out there. We are commissioned to provide certain services in a certain period of time."

"Sunshine": Bernadette's Metaphor

"The one word that came to mind was sunshine. I don't know if it's around the lights off. It's just the seeing her blossom and grow, and

being able to, I don't know. She went from being, I don't know how to describe it, that kind of closed, yeah, it's almost like a closed flower and starting coming to open. The flower was droopy. She was calm and her postural presentation was... I see almost as a dead flower, brown, dark greens, and going from that to bright yellows, sun... It's just bright light.

Almost like going from the dark to the light from bright yellow to quite pure. I'd like to see that continue for her. She can't stay in that state, I think it would be unrealistic to think that she can stay in that state but I think my hope would be that there's more times that she can be in that state and that she can use some of the strategies that she's learnt to help her, so that the duration of time in that light state might be longer. She's almost working out how to go in and how to come out more resilient, being able to choose to be in either state."

Creative Complexity

Participants attempted to summarise effective OT in terms of capturing a totality and solving a complex puzzle. Putting the pieces together was mentioned earlier by Cath. In text metaphors already quoted in this chapter, talk of unpicking the presenting problem was mentioned, and CYP have layers and layers and layers to get through before they feel they can trust the OT, which can take months to get through.

Jigsaw: Emily's metaphor

"Have you seen the jigsaw puzzles that are spheres? It's like that. It's like this whole person and the OT's job is to work out what all those little pieces are and to put the pieces together, by being put in for them to be as whole as possible and to be the best possible within the what they can function".

Containment

Chris described the relevance of her metaphor, again, as an object familiar to OTs (Appendix 9: Q44), with key elements drawn out here below.

“Woven Basket and Lid”: Chris’ Metaphor

“The young person is in the basket, is in the centre of kind of everything that we do and a basket kind of, is protective but it's also kind woven together in all its different strands of woven material, whether it be strong, weak or whatever. Altogether it makes it a strong component and it is all about containment.

I think therapy is about containment. but it's also about ... the lid can come off the basket and allow the young people to grow bigger and express themselves where necessary. The lid can go back on top of the basket of containment is required for a while. It's all those woven strands of the multidisciplinary team and the young person's choices in life and I think all linked together to make that strong cocoon to allow someone to feel safe and allow them to do what they need to do within the basket in order to come out and be a bit more daring and dangerous and risky if necessary when the lids off.

I think it would be the woven strands on the outside could be very colourful themselves and maybe from a distance it may all look like one colour, but when you come in closer it's all very separate and they each have their own unique colour. Woven baskets get splits in them, get little rips in them, but it's the other bits that hold it together when there's a hole in one component of what of the strand. You know, you can take that out and repair it and weave it back in and make it strong again. I guess that's what I am thinking. I guess the person who does the weaving you know could be a combination; I don't think anything can be produced by one person. Maybe, it's the young person on the inside doing the weaving from the inside and maybe it's the therapist that is doing the weaving with the multidisciplinary team on the outside and together they make one thing, which is that basket.”

Emotions and Embodiment

Some metaphors touched on emotions, for the child or the OT. Here, Grace summarised the element of fun.

“Physios will teach you to walk but OTs will teach you to dance”: Grace’s metaphor

“Not to get at physios but... they say... physios will teach you to walk but OTs will teach you to dance. I quite like the idea of OTs helping people to live and have fun in their lives and recognising the importance of that, which I think with the NHS being restricted on money and time and all of those things, that being able to hold onto the things that are

important in people's lives. That's what's important in OT, making sure it's relevant and what the young person or family need.

I guess, to me, you could be plodding a bit through life and taking it as it comes and living but there could be more. And then the difference of having the environment changed, which means you can enjoy what you're doing, or a piece of equipment that makes your life easier. Just the relief of knowing that you don't have to work as hard as you were, to get the same outcome. It's fun!"

"Rollercoaster": Diane's metaphor

"I keep thinking of a rollercoaster, because that's how I feel about working with kids, is that when you actually connect with them and you can see the change, it's absolutely amazing. It's just, the best feeling ever, when you make that connection and you can see progress and development and you can see the children are kind of setting off down a path that is better for them, that they have chosen and they have had a part in. That's amazing. And that's the highlight but then the low bit is kind of really quite horrific in managing the kind of dynamics around working with children and the emotional processes, the risks, the legal system and around kids.

...We actually should be pouring the money into children's services. Because actually if we get that right then we don't need it as much of the rest of it and it makes and that's the lows for me, having to compromise for what's right for kids I don't understand why it's not happening, that's the low.

...if you just put the money in and offered a holistic package of care for kids when they needed it most, that would help I think."

"Red Sphere": Emily's Metaphor

"You feel it here in your heart you know some kind of the sense like an emotional response that he gets in. I guess it does go goose pimply you know sometimes you get the hairs on the back of your arm. I suppose it is an emotional response...

It feels like a heavy feeling but I don't know why, you'd think it would be a light happy feeling. But it's heavy because it's important solid...solid. It feels like a solid circular kind of spherical shape you can just feel there. And it's red, I don't know why it's red. I can feel this red sphere... just here. It's static that you'd think it would flutter or beat or move or something but it's just a solid, round solid shape. It's just, I don't know. It feels like... This is really hard. I've never even thought about this before but I can picture it now you've taken us to it.

I think it's solid rather than light and airy and happy. It just feels like it's something really big and important, something you can grab a hold of, is like physically there. Grounded sense about it. Maybe it's something to do with, you now there's been some breakthroughs or understanding of what's happened and and it feels like you've made some kind of solid connection or sense of what is maybe that's why it's a solid shape. There's something quite grounded, some sort of evidence of what you think of what you feel. Don't know.

Just before...you breathe it in, and then it's there, you get goose pimples and then you just feel it. There, just below your heart. It hasn't got a negative attachment to it but it's not like all happy and joyful either because it is sometimes what, sometimes the reality of what you're feeling sometimes this isn't nice, it isn't a nice thing. It wasn't nice for that little girl to not have a mum to do her hair. I think it's, feels quite serious, it doesn't make sense really cognitively, but it feels, is something to be taken, it feels important. It's big and heavy and serious, it's a solid mass. Some kind of realisation that something big and important has happened is, I think that's how I would probably describe it. It's not really an emotion it is, more like a description. I don't now I don't feel an emotion."

Summary

This analysis has sought to report on the main metaphorical themes (PDTA) highlighted in order to addresses the fifth objective of this research, to gather metaphors of effective OT and offer an interpreted metaphorical explication of it. Evidence has been provided to explore the themes of flow, growth, creativity, containment and the emotions related to the phenomenon. A further level of elucidation will be provided in the discussion chapter, aiming to provide an interpreted metaphorical explication of 'effective occupational therapy'.

Conclusion

In this research, occupational therapists described in concrete terms the activities which, in their experience, contributed to effective occupational therapy with children. The findings in this section relate to the phenomenological descriptive thematic analysis (PDTA) of their transcribed interviews. This thematic data analysis chapter has provided descriptive illustrations of the four main areas which were identified, followed by a thematic analysis of the metaphors which respondents shared to summarise effective OT.

Commencing with the child and their presenting issues, the consistent starting point of OTs was to adopt a child/CYP-centred approach to understanding their problems and motivations. A key initial step was engaging the young person in occupational therapy and accepting the child for whom they are. The OT approach, beliefs and values emerged as a second theme, with evidence provided of the process of building a trusting relationship, assuming a non-judgemental approach, all underpinned by the importance of never giving up, even when engagement or therapy may be personally challenging for the OT. Thirdly, evidence was proffered to support the insights related to the meaning of time, in relation to the phenomenon, to structure therapy and allow the child to utilise the session however they wished, and how this evolved from the beginning through to the end stages of therapy. Fourthly, the OT practice itself was examined indicating dominant themes emerging inductively from the data of environment, meaningful activities, grading, positive risk taking, OT as an embodied therapy, and outcomes related to the child and the OTs' views as exemplified by quotations from transcripts.

The fifth section of this chapter focussed on the thematic analysis of the metaphors which all participants offered to summarise their experience of effective occupational therapy. The metaphorical analysis highlighted certain themes in relation to effective occupational therapy: managing obstructions and creating flow; learning and growth; creative complexity; containment; experiencing highs and lows; bringing in the fun element; and experiencing the emotion of breakthroughs.

This first-level analysis moves the study towards meeting research objectives one (conducting research into 'effective OT'), two (gather data from OTs), three (analyse data and identify themes) and five (gather metaphors of 'effective occupational therapy'). The importance of this chapter is in the evidence it provides of potent emerging themes of being entirely centred on the child's needs, the strength of belief behind the OT approach being based on trust, being flexible and providing an alternative perspective of the child within the MDT. The use of time conveyed consistency and regularity, reflecting a genuine contract to work alongside the young person and enable them to develop skills and be more practiced in making their own choices and guiding their life. OTs facilitate the acquisition of skills by grading activities and environments (to enable positive risk taking and skill development), thus enabling CYP to work towards increasing their independent living skills.

Chapter Six: Data Analysis - Lifeworld

Introduction

Ashworth (2003) identified seven Lifeworld fragments/fractions (see Methodology Chapter) which were created as nodes in NVivo (see Methods Chapter), and against which the eight interview transcriptions were coded. The next seven sections each focussed on one of the fragments, with section eight synthesising the main findings, in line with the third research objective three (see Introduction).

Each section will analyse the transcripts as they relate to the OT and also to the child. This need for differentiation became evident as the analysis progressed, where the intentions from the perspective of the OT would be different to those of the child, though the activity was shared. This research aimed to capture the lived experience of the OT and the headings, which refer to CYP project or CYP sociality for example, are how the occupational therapist described the child's position.

A subtle aspect of this differentiation is methodologically important, in that the area of enquiry is on effective occupational therapy. All analysis needs to focus on this phenomenon, which despite its multiplicity of components, was revealed in Chapter Five to have two distinct players: the child and the OT. One critique of interpretive phenomenological research in nursing has been that instead of focussing on the phenomenon (Barkway, 2001, Crotty, 1996), the focus has slipped onto participant perspectives. Consequently, this Lifeworld analysis reflects the challenge of focussing on the phenomenon of effective occupational therapy, as opposed to the OTs. Recommendations for

future work to directly capture the views of CYP will be included in the recommendations chapter.

Whilst these findings are being reported under separate headings it is important to maintain the approach (Ashworth, 2016) that these are not mutually exclusive categories but fragments, or fractions, which overlap and interconnect. They are an attempt to picture the whole of the phenomenon, with openness to the idea that there may be more, as yet undiscovered fractions. Consequently, reporting on particular fractions will draw in and point towards other, closely-associated fractions, embracing the fluidity of the intersections between them.

Project

All of the occupational therapists interviewed provided a range of examples (see Appendix 10) which related to the project of the child, themselves or the ward. The project fragments consider how the situation i.e. effective occupational therapy, relates to the person's ability to carry out activities which are central to their life and they are committed to (Ashworth, 2003) (see Figure 8, Chapter 5).

The Child's Project

Typically, effective OT happened when the child's project indicated a commitment and motivation to attend OT, sometimes in the face of ward staff resistance. Consistent attendance, with few missed sessions, and the child raising concerns when OT sessions may not happen, indicated a type of contract on both sides to attend. Other elements for effective OT were for CYP to have the opportunity to multi-task and be challenged by the complexity of the activity, have fun and be productive. Expressed goals, such as the CYP wanting to get back to school and parents, indicated their occupational goals to be about participating (World Health Organisation, 2001) and have meaningful relationships (Kielhofner and Forsyth, 1997). Effective OT provides a safe and purposively-selected environment within which CYP feel comfortable and have the opportunity to express themselves whilst doing activities, enabling CYP to find their voice, sometimes for the first time.

The OT's Project

The occupational therapist's project appears to be about: engaging young people; creating a sense of control for the CYP; adapting environments to the individual needs of the child; being consistent, empathic and caring; and using the child's play interests and grading activity to make 'therapeutic work' feel like fun. Effective OT involves consideration of the CYP having a balance of occupations (Kielhofner, 2008, World Health Organisation, 2001), recognising the child as an expert, identifying the CYP's goals and writing care plans together, which can be evaluated against the CYP's progress towards their own aims/goals. Such OT intervention will consider positive risk taking as an approach to skill acquisition for rehabilitation, thus encouraging transfer of learning from OT to other graded environments and aiming to increase independence and confidence. Explaining to parents/others the complexity of purpose behind an apparently fun activity encourages transfer of learning into ordinary life and support from others for CYP to progress more swiftly.

The Ward Project

On examination of the data in relation to the ward project, significant challenges for ward staff were identified which illuminate the context against which in-patient occupational therapy is provided. Despite the desire to provide a consistent approach to daily living, nursing staff are faced with significant challenges which interfere with delivering a reliable approach. Two major factors were identified: staffing and managing challenging behaviour. Staff turnover and the challenge of recruiting, and retaining the numbers of nursing staff required on a challenging in-patient ward, were identified as having a

bearing on maintaining a consistent approach. The project for ward staff was described as firefighting difficult behaviour on the ward, with examples given of staff being strangled and hit. Given this environment, it is not surprising that the individualised risk taking OT approach and the risk adverse, ward-orientated behavioural management approach can be at odds. For one respondent this resulted in the ward gatekeeping opportunities for the OT to take CYP out of the unit unescorted, in order to extend their rehabilitative therapy, such that in over two years, it had happened only once.

Summary

The OT project centres on engaging CYP in a trusting relationship and providing consistent opportunities for them to identify and work towards their goals. The children's projects included a commitment to attend OT sessions and work at their own pace. The project, in relation to the wards, included the desire to have an individualised consistent approach which is derailed by the need to manage difficult behaviour across the ward while coping with staff shortages and turnover.

Self-hood

The Lifeworld analysis illuminated a great deal of depth and colour to the understanding of both the child's and occupational therapist's self-hood. The Lifeworld concept of self-hood poses the question how does this situation relate to social identity, sense of agency, sense of presence and voice? Clearly, there is a level of interpretation on behalf of the researcher, of the meaning of these constructs and how the data correlates to them, which is congruent with the methodology and marks the increasingly interpretive aspect to this data analysis. Nevertheless, contextual quotes (Appendix 11) are provided for objective consideration of this process and further insights from source data.

Occupational therapists described their social identity and sense of agency in terms of the multidisciplinary team, the child and having a voice. Most frequently however, they alluded to the child's self-hood, their sense of having a voice and feeling of their own presence and having a sense of agency (Ashworth, 2003). The dual coding of Lifeworld for both the OT and the child drew out interesting dynamics between the Lifeworld fragments and how they interacted.

The Child's Self-hood

The early stages of children developing their self-hood in effective OT sessions can be seen in them making choices to communicate, giving eye contact and indicating preferences non-verbally. Given time, CYP gradually develop their decision-making skills from being slow and deliberate steps initially, to being

more readily shown in preferences for activities they would like to do in OT, ultimately solidifying into improved social skills and identity.

There appear to be two elements to the examples provided of children opening up in OT, related to the activity at the time. First is talking unrelated to the activity happening, for example CYP who struggle when put on the spot offering a lot more information about what they are thinking and feeling in the more informal environment of OT. Whilst engaged in activities, such as cooking, they are learning how to seek support, which enables CYP to find their voice and emerging self-hood. Secondly, OT offers the opportunity for a more open dialogue for children to find their voice and express themselves through specific activities, such as play. This is an opportunity made available by the OT for the child to choose to open up, verbally or non-verbally, about what is going on for them.

Developing agency and a sense of individualised presence was enabled through providing opportunities for CYP to try new things and access activities, such as making a hot drink and using equipment (kettle) not otherwise allowed on the ward, and have space just to be. Providing a safe environment within which young people can test out their sense of agency, and adopt different ways of being, allows CYP to express themselves in a supportive and predictable environment.

OTs provided examples of CYP developing an emerging sense of self where they were participating more, at home and school (ICF), and choosing to do new things, based on what they had learnt in OT, such as writing instead of playing. Similarly, examples were given where CYP had found something that

they were good at, such as cooking, which helped establish their identity and role in the family, following occupational therapy.

The OT's Self-hood

Being an advocate for the child and the importance of being flexible in order to understand the person as a whole was talked about by the majority of participants. This can create a struggle with the use of standardised assessments which may not really enable the OT to get to know and understand the person, maintain a sense of responsibility to be respectful, get to know and understand them in order to help them, and recommend strategies to help parents and other agencies.

Whilst some participants described the MDT as valuing the role of OT, be it specialised or more generic in nature, others discussed the impossibility for others to really understand it. One participant thought 'effective occupational therapy' to be almost beyond articulation by OTs in practice, but urged colleagues to show the MDT the clinical reasoning behind OT practice which may appear relatively simple.

Examples were provided of the OT's self-hood and sense of agency conveyed by demonstrating they could manage challenging behaviour and provide CYP with the feeling they are safe whilst in OT. They also detailed CYP not feeling worried about being with OTs on their own. This is a significant message for CYP in in-patient settings where they all have a minimum of two allocated staff at all times.

Paradoxically a core element of the self-hood of the occupational therapist is in not assuming a professional expert position (Finlay, 2005), instead convincing the CYP that they are the expert, and this requires a lot of intervention, or expertise, in itself. Stepping away from the dynamics of professional power, and celebrating the child as expert, is systemically at odds with the dominant medical approach used in healthcare and underpins nursing and medics. Studies into such philosophical tensions played out at the level of the multi-disciplinary team have been reported on (Cook, 2004), with some effort to address service user empowerment in policy being made via CYP's services having service user forums.

Convincing a young person that they were the expert and needed to direct their own treatment plans and care was described by some as an important aspect of their advocacy role with CYP.

Summary

This section has outlined the importance of developing self-hood for CYP with mental health and learning disabilities in NHS services. The Lifeworld approach and analysis enabled this element to come to the fore as an important aspect of effective occupational therapy. The objective of this project is seen in the dynamic interplay between these Lifeworld fragments, where the goal or project appears to be to enable the child to establish a sense of self-hood, perhaps for the first time. The primary method of achieving this project of the OT is to enable the child to choose an environment, and activities to do within that environment, that they are comfortable with and which results in an

emerging and burgeoning self-hood for the child. The occupational therapist is *an expert* in both facilitating and developing children to be *the experts* in themselves. Because occupational therapists do not tend to articulate such expertise, those beyond the immediate family may not understand the value of occupational therapy.

Embodiment

How occupational therapy sessions relate to physical feelings, bodily sensations, emotions and disabilities is the focus of this section. Included in Ashworth's concept of embodiment is the child's disability, which was thematically coded as presentation and diagnosis. Also, the Lifeworld concepts of embodiment in relation to the young people, the occupational therapist and the ward will be explored. Embodiment is physical presence, including face-to-face or one-to-one contact: making all OT sessions an embodied phenomenon (Appendix 12).

The Child's Embodiment

One participant spoke of ward staff not tolerating the expression of emotional distress and considered it to be either a concern about the impact on the other young people on the ward or whether it was because staff did not know how to respond to distress.

For CYP who have had PTSD following abuse, the MDT emphasis is on resolving emotional issues through talking therapies, but some CYP do not have the skills, insight or capability to identify and express their emotions. In fact, such interventions can create an escalation in challenging behaviour, with increasing incidents of violence and aggression towards the self or others. Effective OT offered an alternative therapeutic engagement and built up a trusting relationship not based on verbal communication but by mirroring the young person.

The OT's Embodiment

Primarily, all respondents spoke of carrying out physical activities in a physical environment, one-to-one with a child, which in itself positions the phenomenon (effective OT) as an embodied intervention. How then do the OT and child interact corporeally? OTs talked about getting onto the child's level in order to establish a trusting relationship, non-verbal communication often being the starting point. Acute awareness of the child's physical movements was reported by most participants, with examples given of mirroring and moving their own body to align with the movements and gestures of the young person. Building rapport through matching and mirroring their communication and calibrating non-verbal responses was commonly described. Using these, and highly attuned sensory acuity, which recognises the need to align with the other person's model of the world on their terms in order to build relationships and rapport, was described.

Calibrating embodied proximity with CYP with significant MH/LD issues (some with associated challenging behaviour) and negotiating ways of sharing space was rarely articulated by the OT respondents, with the exception of one who identified the need for a young person with autism to have space around him in a car as a coping strategy, a point to be discussed later.

Another lone OT spoke of providing physical reassurance by touching a distressed child's shoulder, which is surprising when some of these children are living away from home for the first time, and sometimes for extended periods of time. How do in-patient services provide the warmth and comfort a

child would naturally seek at home? This is stark contrast to restraint and seclusion which were widely talked about. Thus, this one example stands out as having a potentially powerful contribution to effective occupational therapy for children.

Feeling the emotional impact of the child's progress when significant breakthroughs happened in therapy was mentioned by some participants (see Chapter 5 metaphorical analysis and embodiment) in terms of feelings evoked, tears, and a sense of the "Ah-ha" moment in therapy being made manifest in their body and emotionally. This finding will be further discussed in later chapters.

Occasionally participants appeared to enact the presentation of the child or young person or their parent, empathising with their embodied issues or expressing others through their own body language and words. The OT's body language appeared to reflect either the CYP/parents inner vulnerability at the outset of OT or the outer strength at the end of the intervention, and appeared to resonate with the embodied understanding they had through one-to-one sessions with an individual.

Ending occupational therapy was described by most participants as involving making or having something physical to take away – a card, a list of tips or strategies, plans and plants, with one participant identifying these items as a transitional object, symbolising physical connection and contact after OT. A similar concept previously recounted a tight hairdo, reminding and reassuring the child of the OT's presence when they are not there, indicating such

transitional concepts to be present during therapy as well as at the end. This was not widely discussed and might be worthy of future discussion.

The Ward Embodiment

The gate-keeping function of ward staff to decide whether young people go off the unit without other additional staff to manage challenging behaviours significantly impacted on the OT being able to take CYP out for positive risk taking rehabilitative OT. The sense that ward staff were having to manage a ward full of challenging young people, compared to the individualised approach of the OT, highlighted different approaches to risk management and hence the level of bodily/environmental freedom experienced by the young person, and the OT.

Summary

This section explored the embodied nature of occupational therapy with CYP. As a predominantly face-to-face and individual contact, the phenomenon of effective OT raises feelings and emotions, as well as having a physical dimension. On a practical level, many sessions are activity-based and can be very active for both the OT and the young person. It involves a corporeal experience, with all the anatomy and physiology inherent in that, as well as the emotional reactions included in the concept of embodiment (Ashworth and Ashworth, 2003).

Sociality

Sociality includes a concept of relations with others, so for this study raises the question how does effective OT impact on relations with others? This Lifeworld fragment was analysed from the perspective of the child's sociality (as reported by OT), the OT's sociality in relation to the child and the OT's sociality in relation to others. Appendix 13 provides examples from which interpretive extrapolations are summarised below.

Child's Sociality

The importance of the child linking OT sessions with their world outside was widely reported, with the transfer of learning to other environments (e.g. CYP bringing cakes, lights, charity work back to the ward from OT sessions) being seen as a good indicator of effective occupational therapy. CYP opening themselves up to feedback and potential criticism, being a gauge of increased levels of resilience or confidence, was compared to their initial presentation. Linking in and out of OT sessions by reporting back on progress between sessions or bringing the OT into other sessions indicated increased social connections related to activities and occupations.

Presenting as less suspicious of others and more comfortable in themselves was reflected in self-care, dress and makeup as outward signs of improved sociality of the young person. Developing relationship skills and learning to be more selective, yet open and trusting, with different people, were descriptions used when OT had been effective.

OT's Sociality (with child)

OTs reported providing stability through transitions and change, having established trusting relations with CYP. Fully embracing this role can create conflict for the OT, reflecting a philosophical professional tension to not create dependency, resulting in an underplaying of the clinical reality of bridging transitions for vulnerable CYP through OT. The value of preserving a placement (school or home) and extending periods of stability was undermined by the anathema of emotional dependency from the CYP. Whilst some respondents actively worked with such undercurrents supported by safe, open supervision and psychodynamic awareness, others negated this aspect of effective OT and were surprised by the strong emotions expressed by CYP in OT, before showing concern for the seeming failure it reflected on a them. However, the joy of seeing the positive results of permanency outweighed the worry of fostering reliance on occupational therapy, or more accurately, the occupational therapist.

OT's Sociality (with others)

Providing effective occupational therapy to parents, whilst acting as an advocate of the child, was reported by several respondents. The aim appeared to be to re-empower families, using a considerate and gentle approach to increase their realisation of the issues, in a non-blaming and non-shameful way. Cath stated the:

“whole essence (of OT) being to re-empower the family units for them, not to become reliant on an expert because actually they are the experts and they are all a family.”

Whilst a Lifeworld coding for 'Ward sociality' did not emerge from the analysis, it is perhaps a significant point to reflect upon. The absence of a positive narrative about ward culture could lead the reader to consider OT as an oasis of positivity in an otherwise hostile environment. It is important to remember the research aim and area of enquiry, as responses were to questioning in the realm of 'what is effective occupational therapy?' Not what is an effective ward or nursing approach with CYP. Thus, caution must be applied in drawing conclusions in the absence of data, which was never sought. Nevertheless there are some indicators of concerns raised by OTs about ward staff not allowing children to express emotions, for the impact on others (sociality) or how they manage such emotions (their own sociality). There was also little comment in this area about relationships with other children (child-to-child sociality), which in teenage years are usually highly influential relationships. A ward-based behavioural management approach could lead to the de-personalisation (McAnelly et al., 2015) of the child and some OTs described staff seeing the diagnosis or behaviour and not the child. Resisting objectification of the child did emerge as a category, reported by one OT as needing to "get the job done", a point of reflection which enabled her to refocus on the individual needs of the child, and which linked to the Lifeworld fragment of embodiment. Objectification can also be seen in blanket rules that apply across the ward and do not account for individual need.

Summary

In this section on the Lifeworld fragment of sociality it is clear that for the CYP and the OT significant relationships are established which, when well understood and supported, create a foundation from which children can go on to create further relationships and connections with others.

Spatiality

In this section, consideration is given to how occupational therapy with CYP relates to spatiality, the geography of place, or environment. This is about the space and place that OT and CYP need to go to or act within (see Appendix 14 for related quotes).

Child Spatiality

Many respondents described the contextual difference between the ward environment and OT, whereby within the ward behaviours must be managed, primarily due to time pressures, whilst OT would seek to understand what was driving challenging behaviour. Some OTs described challenging ward rules and the importance of seeing the child in their living environment, in the spaces where they need to express themselves.

Careful preparation by reading notes and observing behaviours was the strategy used by some OTs to decide on the best first place to meet the young person, indicating that the grading of the environment was often the first step in the process of engaging the child. This is because it was used to optimise the likelihood of success by facilitating the child to feel as comfortable as possible.

OT Spatiality

Despite the challenges of having to meet waiting list targets, taking time to soften the clinical space within which the child is seen was reported by several respondents as crucial. Aiming to create a welcoming environment, clinical

equipment and other items could be removed or covered in order to make the space less intimidating. Inspired by clinicians such as Monica Lanyardo (Lanyardo and Horne, 2009, Lanyardo, 2016), safe OT spaces are created to put the child at ease and convey the respect of the OT.

Ward Spatiality

One of the principle differences between the ward environment and that in occupational therapy is the approach taken to risk taking. Access to certain things is restricted for many people on the ward, with the exception of OT being risk assessed and agreed with the MDT prior to sessions. Behaviour management approaches allow increased access as a sign of improvement and reduces access in response to negative behavioural issues. Consequently, OT provides an opportunity for access to equipment, and positive risk taking otherwise precluded in other environments. Where an individual requires a more risk-taking approach, the ward system and blanket risk averse approach can undermine a more rehabilitative approach.

Summary

Issues of spatiality are key to effective occupational therapy. The overall aim of helping the young person to engage and utilise the space to further their occupational goals can be addressed by the ability to manipulate the environment. Participant evidence indicates that the purpose of ensuring the CYP are comfortable in the space, enables them to engage in the therapeutic process more easily and empowers them to have a voice. Overlaps are seen

here with the Self-hood Lifeworld fragment and the development of the child's social identity and sense of agency. References made by participants drew upon issues of temporality and timing being important, while different spaces or spatiality factors impact on the embodied experience for both the child and OT. Are they in a small room, requiring close contact and less freedom of movement, or are they using a gym space which enables distal and proximal levels of embodied experience? Finally, this section has drawn a picture of life on some of our CYP in-patient wards, where the contrast of calmer, risk-taking approaches within a one-to-one OT space must seem like a stark contrast for CYP to global behavioural management, ward approaches which err toward risk aversion.

Temporality

Temporality, as defined within the Lifeworld, is described as relating to time, duration and biography. This analysis starts with the biographical aspects of effective OT and then moves onto a broader Lifeworld analysis in relation to temporality as OTs describe it for children, themselves and ward staff. This will be further explored in relation to specific words and the meanings participants gave to the importance of time.

The concept of time and the existential nature of the Lifeworld approach will then be looked at in relation to the other Lifeworld fragments.

Child Temporality - Biography

Often, the use of future-looking biographies were how OTs assessed the outcome of interventions, compared to the trajectory the child was on. The child navigating a different biographical course was used as a measure of the effectiveness of occupational therapy.

The following observations (see Appendix 15) provide a flavour of the issues a child's life reported retrospectively by OTs and then forwards to new possibilities following effective occupational therapy and related biographical accounts.

Looking Back

The range of biographies captured the unique experience of this cohort of occupational therapists. Issues from children varied, ranging from inability to tolerate feedback to experiencing sensory overload, trauma and abuse. In

dealing with children lacking confidence and identity and struggling underneath a violent and aggressive presentation, occupational therapy was described as effective when it enabled CYP to alter the trajectory they were on, transforming managing presentations into being more insightful, capable young people participating more fully in life.

Looking Forward

Positive, forward-facing biographies of CYP were identified with important features including the child taking the initiative with their care plan, identifying and working on independent living skills and bridging key life transitional points. Establishing routines and habits with life skills included: independent travel; cooking skills; getting fit; opening a bank account; and returning to the school/family environment. Becoming an expert in themselves, and building emotional resilience whilst reducing behavioural risks, were all reported as cornerstones of effective occupational therapy and a more fulfilling life.

Occupational Therapist Temporality

The OT's story or biography in relation to CYP alluded to the duration of contact from weeks to eight years, and the transformation over that time. This was powerfully illustrated by Cathy:

“yes, I guess the boy I have restrained, the only boy (who sank his teeth into my hand and left a scar), and then hearing him say ‘I don’t want you to leave me’, that is the realisation of, the effect of the work and the relationship”.

The message of the importance of the persistence in establishing a relationship was repeated by Chris:

“But I think that relationship, as I said right at the beginning, I made an effort and I persisted and I didn't give in, so it culminated in him feeling confident and able to talk to me.”

Ward Temporality

Finally, the temporality of the ward was described as being in the unenviable position of firefighting violent and aggression behaviours on the wards. These are mostly acts of self-harm by the child towards themselves, but also occurred between children, and towards staff. Ward staff were also at the interface of needing to hurry the therapeutic process along due to external commissioning and pressure on beds, conveyed by senior managers. Within this challenging ward temporality is the oasis of finding the time to non-judgementally support OT staff in times of doubt, frustration and exhaustion.

Summary

It is clear that in the lived experience of OTs, time is used from the very beginning of occupational therapy to convey consistency and regularly of contact, and a desire to engage, even when the child avoids or rejects that offer initially. Regular sessions are an expression of commitment and persistence, and a way of communicating a visible, caring and compassionate approach. Children and young people are offered time in OT sessions in a way that seeks to maximise their control and level of choice on whether to engage.

Biographically, OT's lived experience showed that children often enter services with significant stories of their past. OTs commonly used revised, forward-

looking biographies to measure and show evidence of the effectiveness of occupational therapy for the young person.

Discourse

Lifeworld discourse analysis, or the investigation of terms used to describe phenomenon (considering terminology, language from particular backgrounds educationally, or ethically, for example), was analysed in relation to the young person, the OT and the researcher. The following summary picks out some specific examples of note. The primary analysis in this research on the language used by participants, focussed on the use of metaphors to summarise effective OT, which have been previously reported in Chapter Fives' metaphorical analysis.

Discourse of the Young Person

One respondent identified a subtle difference in the language and words used by CYP when they are truly engaged in OT. Linking this with the belief that therapy brings to conscious awareness previously hidden thought processes, children's ability to articulate their difficulties was used by some OTs as a measure of effective occupational therapy and signifies major shifts for the young person.

Discourse of the OT

The alternative perspective that OT brings to discussions about young people was raised by several of the respondents. Holding a more positive narrative

about children and the instillation of hope for both child and the team (Yalom, 1980), appeared to hold important functions for the team around the child.

Discourse of Researcher

The reflexive account in section 8 provides an overview of the researcher's discourse. This reference in particular is about the term effective occupational therapy, which was used in the interviews. Some examples of how this was explained by the researcher are captured below.

Whilst academically there is much debate about the term, interestingly none of the clinicians in the study asked for further clarification or definition, or offered their own definition, of what is meant by effective OT. This is surprising and points towards the cultural acceptance and prevalence of the use of the word effective and effectiveness in the NHS of such terms.

Terms used to illicit descriptions of effective occupational therapy appeared to draw on the narrative of magic, perhaps an assuming of the unknown and as yet hidden phenomenon of effective occupational therapy. These included the concepts of making a difference, finding the magic, when OT has done the trick, all of which are a distancing from the positivistic concept of measuring effectiveness. Finally, an aspect of questioning appeared to lean towards a ranking of what was most effective, relative or more effective than something else. It is also interesting to note the neuro-linguistic pre-supposition that effective therapy had happened.

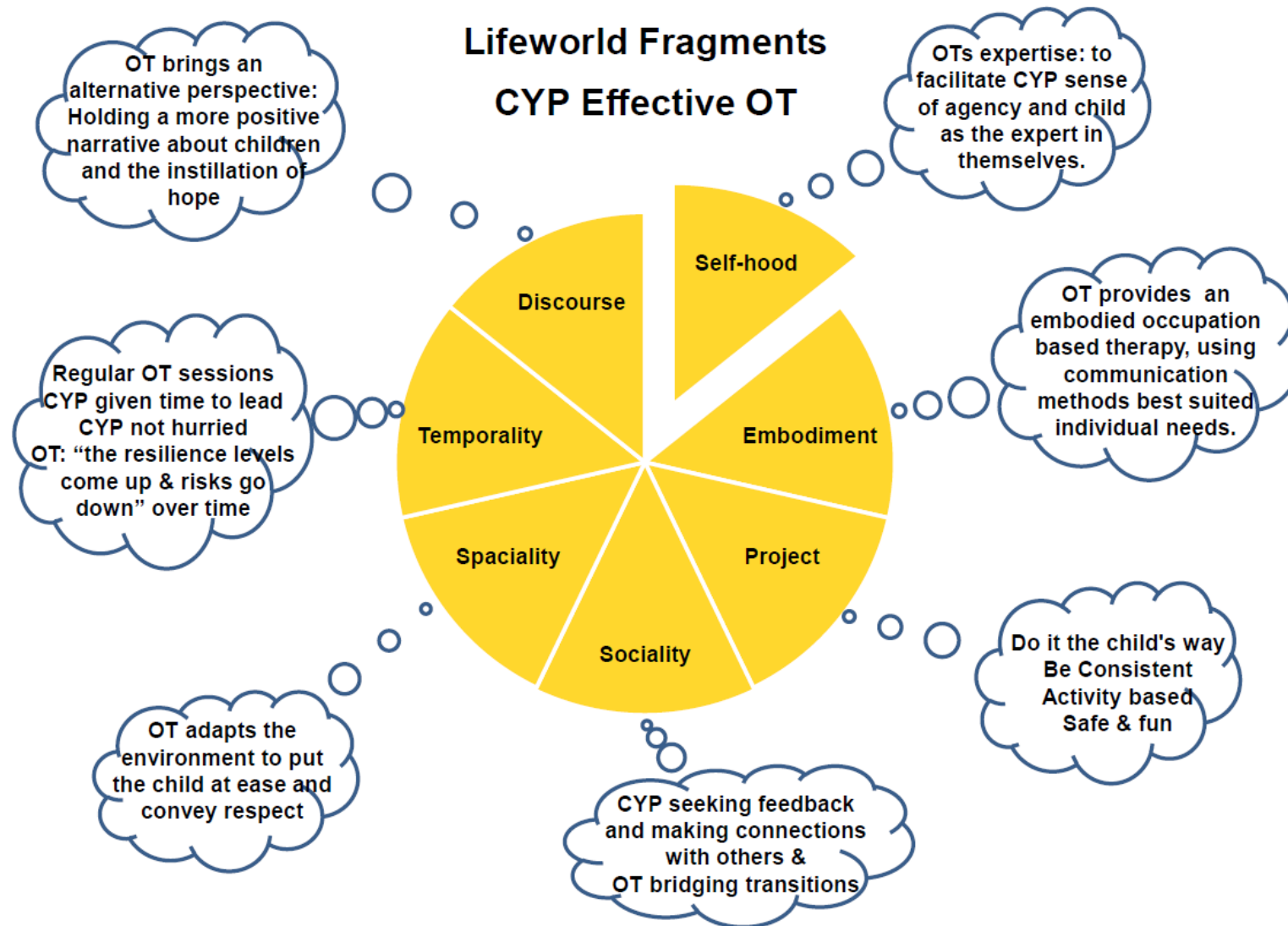
Summary

In this section issues around the terms used to describe things have been analysed from the perspective of the CYP, the OT and the researcher.

Syntheses of Lifeworld Fragments

A visual summary of this Lifeworld analysis can be seen in Figure 9 below, which captures the key aspects of each fragment. A synthesis of Ashworth's seven Lifeworld fragments will now be undertaken to illuminate the dynamics between them and identification of key aspects of effective occupational therapy with children and young people with mental health and learning disabilities.

Figure 9: Lifeworld Fragments Visual Summary



Lifeworld Summary

The OT's project, their ability to carry out activities they are committed to, was clearly seen within occupational therapy for children and young people with mental health/learning disabilities. During the initial phase of occupational therapy there is overwhelming evidence that they do everything possible to engage children with MH/LD issues. By being highly adaptable and flexible they convey a level of acceptance of the child for who they are whatever their behavioural presentation. Their approach is underpinned by beliefs in the importance of being consistent, respectful, caring, compassionate, fair and gentle.

Temporality was a core component of conveying their commitment and determination to engage and build a consistent, therapeutic and trusting relationship, which conveyed their belief that the child can take the opportunity to develop their own self-hood. It enabled the OT to offer regular and repeated sessions (often weekly one-hour sessions) and make themselves available to the child whether they wished to engage or not. Stemming from the temporality fragment, occupational therapists utilised environmental manipulation (spatiality) in order to provide a safe and meaningful space, within which the child can carry out activities which are meaningful to them. Crucial to this endeavour is this child-centredness of the occupational therapy approach which shows an acceptance and validation of the child as their own expert and a leader of their occupational therapy session.

A core aspect of effective occupational therapy with CYP is developing a trusting, non-judgemental relationship (sociality), where the child is truly seen as an individual with unique needs, as having ways of expressing themselves and as an expert in their own recovery. This can appear in contrast to a system

or culture which can be depersonalising, or sees the behaviour, often challenging and requiring management, rather than the child.

The manipulation of the environment (spatiality) in order to maximise the child's engagement within it happens prior to the child being in it. OTs prepare and plan for the first/initial environmental contacts as an important part of the engagement and project skill development for the child. Successful engagement in the environment or shared space is the first step of OT. Manipulation of the environment to maximise opportunities for the child to take the initiative and be successful, is core to OT. Transfer of learning in OT to other environments is used as a key outcome measure for OTs.

Effective occupational therapy with CYP is an entirely embodied experience (embodiment), the therapist and child sharing the same space/activity. The only rules established at the outset of therapy are that child and therapist safety is paramount. This conveys the importance of keeping the CYP safe and that the therapist is in control of this aspect of the session. It creates a safe and holding environment within which the child can maximise their sense of control and agency.

Core to OT sessions is positive therapeutic risk taking, aiming to extend the skills of the CYP so they learn and develop mastery (project) and their ability to carry out activities central to their life. This mastery directly feeds into their sense of agency and identity, i.e. their self-hood. The child developing their self-hood is a key way in which OTs measure the progress of occupational therapy.

OTs utilise their expertise not to assume a professional expert or power position, preferring to ensure the child as the expert in their own care. As such,

they provide an alternative perspective/view of the child within the MDT and operate a non-medicalised view of health and wellbeing. Lifeworld discourse analysis identifies that OT uses creative, empowering, goal-orientated linguistics and deconstruction of cultural norms/stereotypes, challenging the systemic use of the language of the medical model of doctor or nurse as expert, deconstructing such concepts by seeing the child as the expert.

It would appear that this facilitation of the child lead role is an attempt to provide an externalised representation of a higher endeavour, to create or strengthen the child's own internalised self-hood. The objective of this project is seen in the dynamic interplay between these Lifeworld Fragments, where their goal or project appears to be to enable child to establish a sense of self-hood and, often for the first time, a sense of their own agency.

The primary method of achieving this project of the OT is to enable the child to choose a meaningful project to them, which is housed within a carefully chosen and graded environmental space. Drawing on skills of assessing motivation and meaningfulness of activities, the occupational therapist seeks to facilitate the child to carry out an activity important to them, within that environment, which they are satisfied with.

Facilitation which enables the child to complete their chosen project results in an emerging and burgeoning self-hood for the child. Part of the social identity of the child's self-hood is tested and explored through sociality. The impact of effective occupational therapy on the child's sociality is that they in turn can develop communication skills, both verbal and non-verbal, and relationships within their own right and which they choose to make.

Conclusion

This chapter has provided a comprehensive analysis of the data in this research from the perspective of identifying Ashworth's seven Lifeworld fragments (Ashworth, 2003, Ashworth, 2016), and in so doing satisfies research objective three in particular, and objectives one and two. As clarified in the Methods Chapter, these seven fragments were created as codes/nodes in NVivo software and all eight interview transcriptions were coded using these. This allowed rich descriptions to be collated under each Lifeworld fragment for each individual interview and then for the hermeneutic expansion of perspective across the whole data set.

Each of the seven sections provides clarity regarding the lived experience of occupational therapists in their descriptions of effective occupational therapy with CYP. Section eight provides a valuable synthesis between the fragments, gearing the reader towards ever more dense and nuanced insights. The combined understandings garnered from the thematic and Lifeworld analysis will now be brought forward and considered against the occupational perspective of health.

Chapter Seven: Occupational Perspective of Health & Effective Occupational Therapy

Introduction

Drawing from the thematic (Chapter five) and Lifeworld analysis (Chapter six), this chapter seeks to further examine effective occupational therapy with CYP using an Occupational Perspective of Health (OPH) (Wilcock and Hocking, 2015) and address the forth research objective: To interpret the meaning of the lived experience of effective occupational therapy within the OPH.

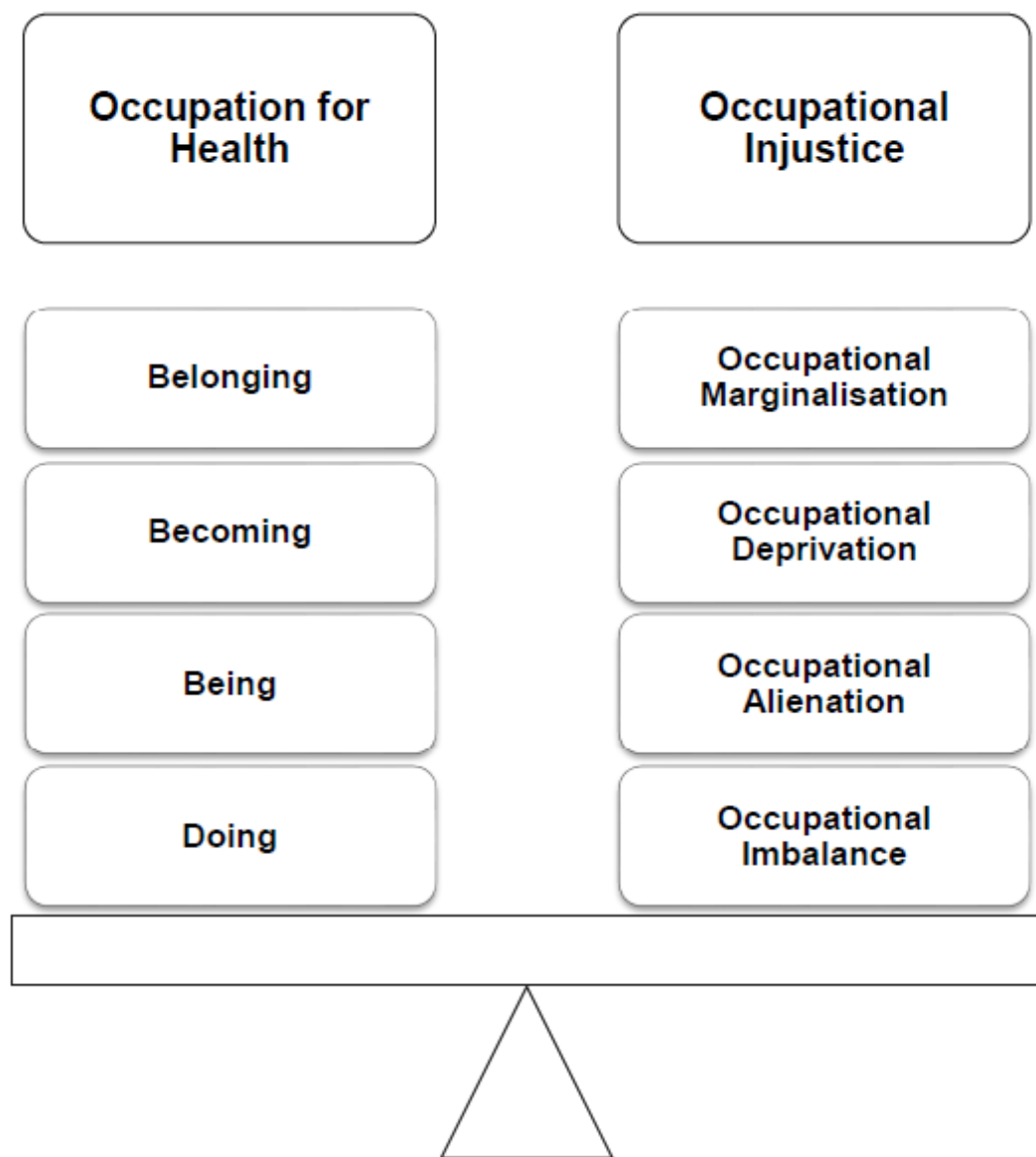
The importance of activity (task execution) and participation (involvement in life) for children has been previously established within the WHO International Classification of Functioning (2015). Applying the ICF model in OT practice has met some criticism (Farrell et al., 2007) regarding the meaningfulness of its terminology and the lack of granularity in exploring occupational performance underpinning participation. Whilst there are differences between the terms participation and occupation (Wilcock and Hocking, 2015), the drive for young people to have meaningful occupations which enable them to fully participate in society is equally important for those in hospital or at home (Ziviani and Rodger, 2006).

As outlined in chapter two, an Occupational Perspective of Health has been used to provide a more granular and relevant conceptual framework by which to analyse activity and participation in relation to effective OT with CYP. By investigating the contribution of occupational therapy to enhancing the health of CYP with MH/LD using the OPH, this research also responds to Hockings' (2009) call for clinicians to consider the framework and to note the difference between occupational performance and occupation. Subsequently, the

structure of reporting the analysis will identify performance issues in the first four sections and focus on occupation in section five.

The thematic and Lifeworld analyses reported in chapter five and six were coded against the Occupational Perspective of Health (Wilcock and Hocking, 2015). Analysis of findings using the OPH guides this discussion focussed on the areas of doing, being, becoming and belonging. Alongside these areas, their associated occupational justice (see chapter two) issues will be considered for risks of: occupational imbalance, occupational alienation, occupational deprivation and occupational marginalisation (Wilcock, 2006), as illustrated in Figure 10 below. This chapter will conclude with a summary of the lived experience of effective occupational therapy as it relates to the Occupational Perspective of Health, particularly in relation to doing being and becoming and belonging.

Figure 10: Scales of Occupational Justice



Doing and Effective Occupational Therapy

This section reports on the analysis related to 'doing' and the associated occupational injustice of occupational imbalance (see Appendix 17).

Doing and Thematic Analysis

CYP Centred, Authentic Relationship & Rapport

Effective occupational therapy is actively centred on the child, not on the system, and often advocates for system changes to resist objectification (Finlay, 2005) of the child and empower the CYP to lead and maximise their occupational performance (Yerxa, 2000), in order to improve their sense of agency and self-hood through doing. OT with CYP is an embodied phenomenon, involving physically doing activities together and playing on the child's level, developing a therapeutic friendship and establishing boundaries and rules which ensure safety. Emphasis is given to child-centred practice and encouraging children to be the expert in themselves, with concerted efforts not to foster dependency. Supervisory monitoring and support for OTs to reflect on the emotional connections between therapist and child requires a trusting, emotionally safe and honest relationship. Wimpenny et al. (2014) found this element of seeking supervision and insight to be central to effective occupational therapy with adults, which resonates with the findings of this study.

Micro-grading Activities & Occupations for Participation

Effective occupational therapy involves a granular, or micro, level of grading of activities to ensure success. CYPS occupational therapists are extremely resourceful in the use of environment and activities to maximise the child's occupational engagement and develop the skills they need to participate through doing. The OT addresses a range of occupational needs, not least providing a range of activities with an element of fun, thereby getting a real picture, beyond diagnosis and medication, of what the child doing. CYPS occupational therapy provides opportunities for increased occupational balance addressing all aspects of activities of daily living (Anaby et al., 2010).

This study found that children tended to "open up" (talk) whilst engaging in occupations, rather than when asked directly, with cooking in the kitchen being an opportunity taken to share memories, both good and bad.

Micro-grading Environment

The results show that effective occupational therapy happens when the occupational therapist adapts the environment to enable children to own the space.

Regular, Reliable 'Contract' of OT Provision

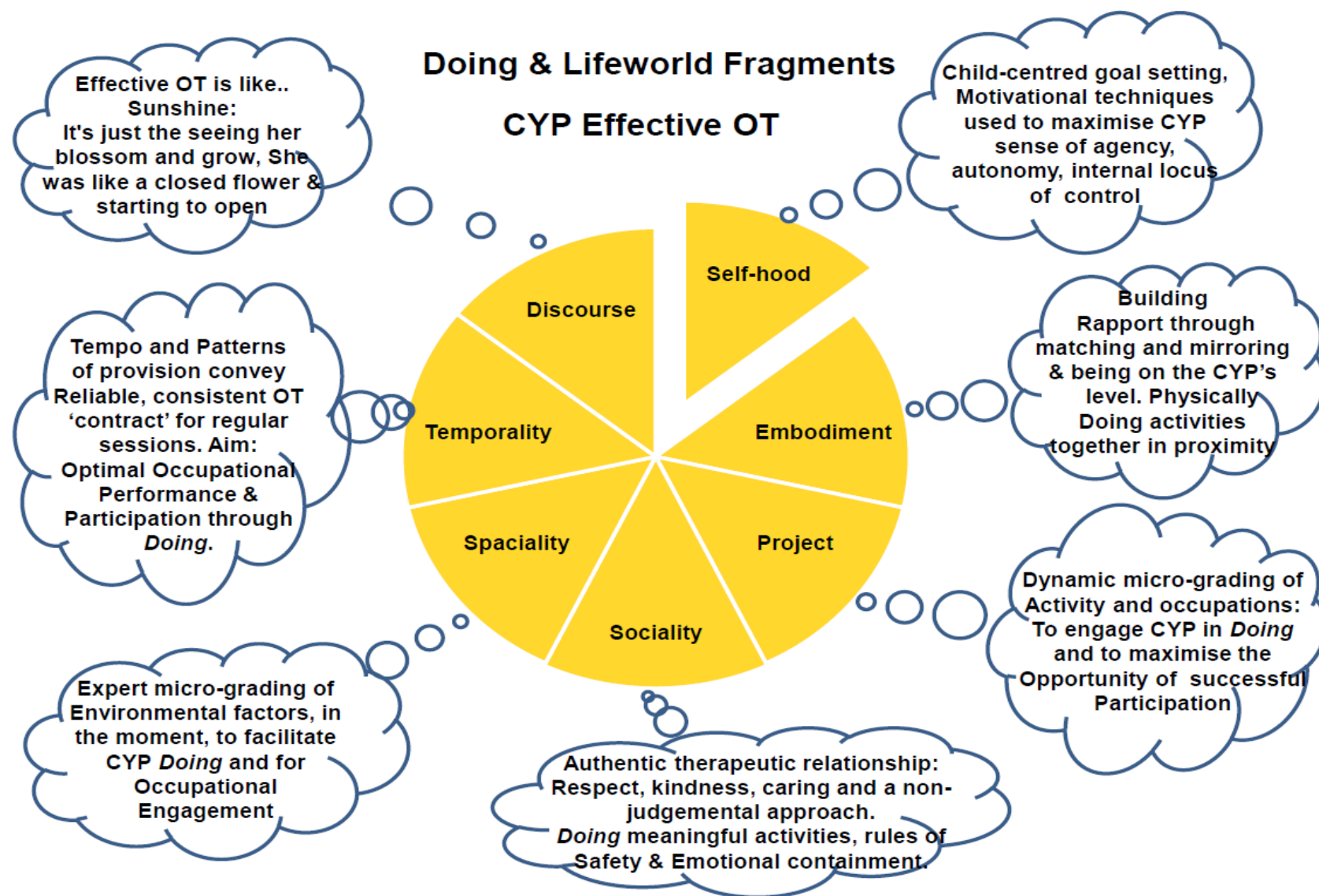
Considering the Lifeworld findings related to temporality, effective occupational therapy in relation to doing utilised particular patterns and frequencies to convey predictability. Often OTs offered regular one-hour sessions on a

weekly basis, not uncommonly over 6 to 9 months, i.e. circa 30 sessions. The question of dosage, how often and how frequently, was surprisingly consistent, with weekly one-hour sessions being the norm. Within this infrastructure lay consistent implicit rules of not rushing the child, permission not to have to do a lot, and OTs learning the skill to take time. In this way CYP's development skills are at a pace comfortable to them and at the rate which they can cognitively process new information and the overall experience. OTs described a sense of time distortion, with slow decision-making of the child, or repeated activities, seeming like endless time in sessions and the fortitude to stay in the session and never give up appeared to have an altruistic quality about it.

Doing & Lifeworld Analysis

The key aspects of 'doing' and 'effective occupational therapy' from a Lifeworld perspective are shown in Figure 11 below:

Figure 11: Doing and Lifeworld Fragments



Occupational Imbalance: Risks and Opportunities

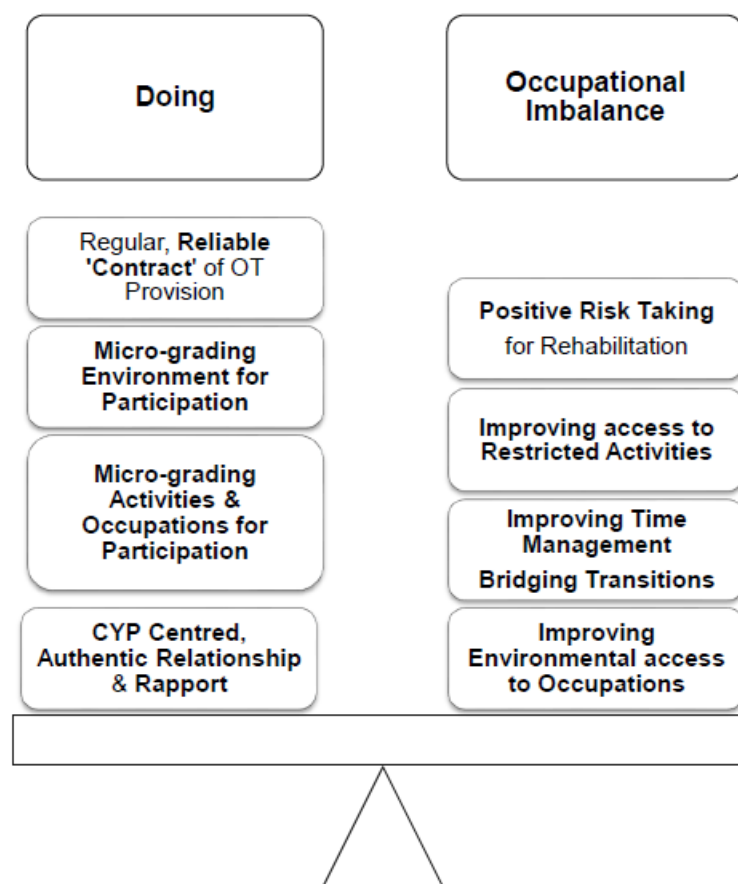
Occupational imbalance is defined as un-occupied, under occupied, over occupied or having an imbalance of meaningful activities (Wilcock, 2015).

Visual Summary of Doing and Occupational Imbalance

Figure 12 provides a summary of the key issues that address occupational Imbalance.

Figure 12: Doing and Effective OT

'Doing' and 'Effective Occupational Therapy' with CYP



Spatiality: Improving Environmental Access to Occupations

This research highlighted OTs addressing issues of occupational imbalance: creating play environments; creating developmental opportunities; and providing bright and light environments such as an OT room with a view. This is in contrast to the ward, which has dark-tinted privacy glass. OTs described adapting environments to make them safe and supportive, with many children having come from unsafe and supportive environments. In contrast to the ward environment, occupational therapy created opportunities of doing and access to environments.

Temporality: Improving Time Management skills; Bridging Transitions

OTs appeared to offer a holding and supporting function to bridge significant transitional life events, such as changes of carer, school or social worker. This, in turn, prevented an occupational imbalance happening. There appeared to be a health-promoting aspect of occupational therapy, maintaining occupational balance through key transitional points, which was happening but not considered to be legitimate occupational therapy or part of the therapeutic intervention.

The OPH model provides a particularly useful way of thinking about the various approaches OT can have. The OT had supported the child through doing, and subsequently developed their sense of being, becoming and belonging. However, they had failed to recognise the important role they had in preventing

an occupational imbalance some CYP. Part of the difficulty in so doing was the philosophical tension it raised for the OTs, who felt and feared that creating dependence was contrary to their role and failed to recognise it as a legitimate OT function from an occupational injustice perspective.

The Lifeworld theme of temporality showed an important role in relation to doing and the risk of occupational imbalance had they not offered time away from the confines of the ward and opportunities for children to be occupied, due to limited activities or meaningful occupations on the ward.

Project: Improving Access to Restricted Activities

Occupational therapists identified occupational imbalance issues resulting from CYP being in a secure unit or a seclusion room, and being under-occupied. In terms of embodiment, one occupational therapist described providing reassurance to a child through touch following an incident, but there was little mention of reassuring touch, despite some children living on wards for years. Incidents of violence and aggression and PMVA (prevention and management of violence and aggression) techniques were alluded to by the OTs in relation to the use of restraint and responses to violent outbursts by the CYP. OT addressed occupational imbalances through offering activities off the ward and within the community.

Self-hood: Positive Risk Taking for Rehabilitation

OT provided an opportunity for access to restricted activities like making a hot drink, which would otherwise be locked or off-limits. Taking a positive risk

taking approach mitigated for the demotivating impact of system-wide behavioural management approaches, which could result in feeling under-occupied and untrusted.

Clearly, occupational therapy has a role in judging the optimal balance of and time to be engaged in occupations whilst on an in-patient unit, i.e. OT assessment and intervention related to individual needs and maximising the occupational performance of the child.

Summary

The thematic analysis identified four areas associated with doing. When occupational therapy is most effective it is an authentic, CYP-centred relationship where OTs use expert skills in micro-grading activities and environments to maximise the participation of the child. The OPH analysis pulled out specific elements of Lifeworld fragments, deepening the level of analysis and understanding of the phenomenon of effective occupational therapy with CYP with MH/LD, summarised as:

“Being like sunshine: it’s just ...seeing her blossom and grow”.

Four distinct areas of OT involvement to address occupational imbalance were identified: improving environmental access to occupations; improving time management and bridging transitions; improving access to restricted activities; and positive risk taking for rehabilitation. The next section will take the same approach to the OPH aspect of being.

Being and Effective Occupational Therapy

In this section analysis of effective occupational therapy in relation to being and the occupational justice issue of occupational alienation will be provided, along with the occupational therapy role in relation to seeking solutions to identified issues (see Appendix 18 for quotes).

Being and Thematic Analysis

Being within the OPH relates to those quieter times when one reflects on what one does and the roles adopted in the occupations engaged in.

Child-Centred and Led by CYP as Experts with Potential

Effective occupational therapy in relation to being in this study is the child-centred focus, a finding which resonates with the WFOT statement that the essence of occupational therapy is client-centred. The child is seen as a person with potential and the privacy, respect, empathy and non-judgemental nature of the OT's approach is of paramount importance. The primary purpose from the outset is to establish a caring therapeutic relationship, allowing the child to feel comfortable. The actual relationship between the OT and CYP was crucial, establishing a meaningful, truthful professional relationship. The notion of consistency was widely reported as important and appeared to have multiple purposes of conveying a determined perseverance to get to know the child, and to allow them time to engage when they wanted to, providing emotional containment and stability. Effective OT was evaluated by the OTs to assess

the child's developing a sense of self and emotional connection with other young people.

Sense of Self-hood and Agency

The occupational therapists facilitated the child to establish a sense of self-hood and agency through making and achieving personally meaningful goals. The occupational therapist appeared to measure the effectiveness of occupational therapy in terms of the child feeling more confident and moving on, being articulate and able to open up, being able to adopt different ways of being and challenging previous negative notions of themselves. There was clearly an embodied nature to being within effective occupational therapy: the child experiencing a sense of self-control over their behaviour, thus increasing their sense of self and being the world.

Advanced Non/Verbal Communication Skills

The importance of effective communication was emphasised, with concepts of the OT keeping the children safe and saying things in the right way having a big impact. The qualities required of the occupational therapist in order to deliver effective occupational therapy were the ability to keep calm and be able to tolerate silences, and being flexible to use pen and paper and other activities as alternative methods of communication.

Altruistic Tenacity: Flexible and Calm OT

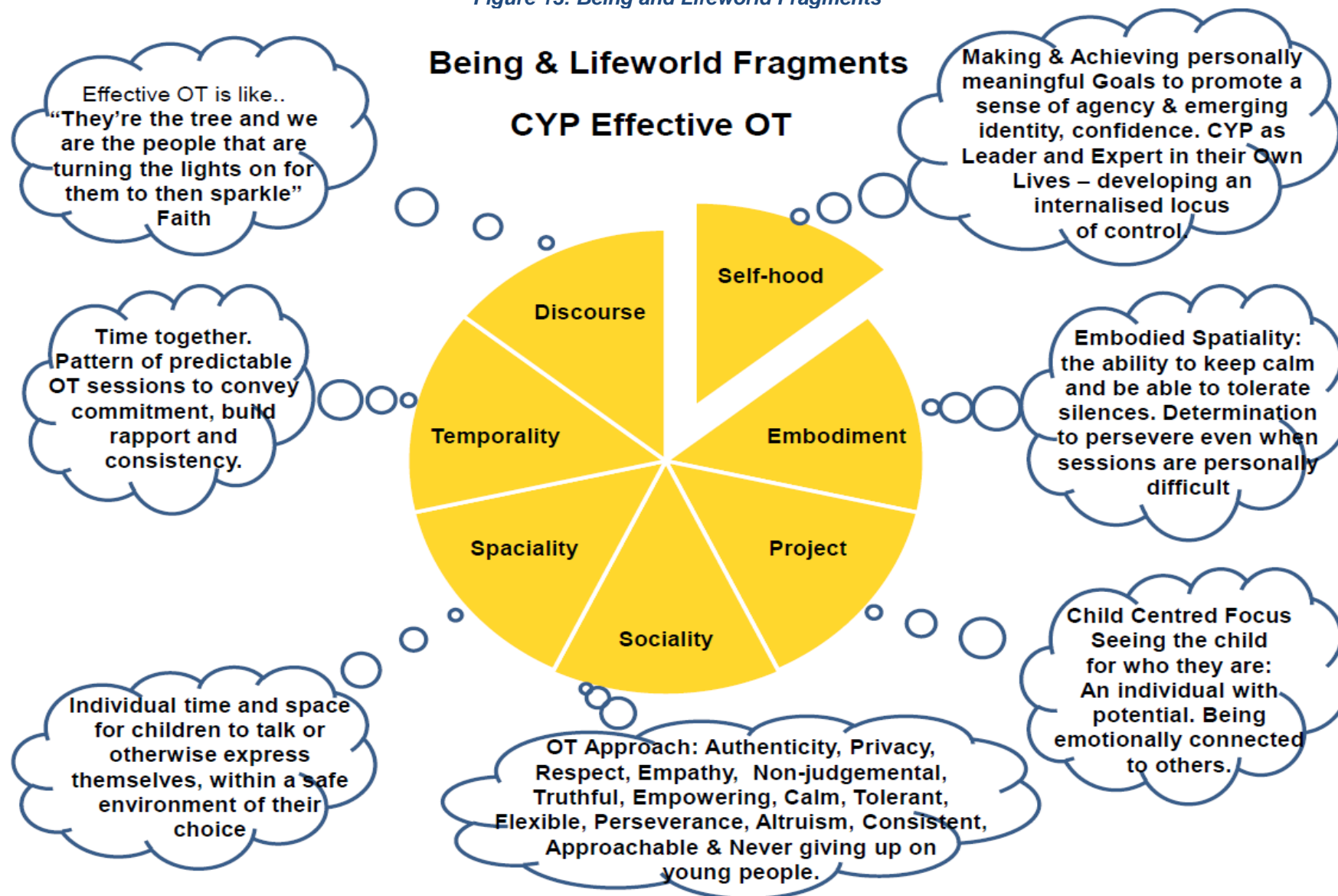
An altruistic determination to persevere even when sessions were personally difficult appeared in the discourse of never giving up on young people and

offering repeated opportunities to engage in occupational therapy, while not forcing them to do so. At a minimum, children proved to themselves that they could make and develop relationships with people. The OT remained consistent, approachable, trustworthy, and re-empowering of the child to lead sessions and be the expert in his or her own lives.

Being and Lifeworld Analysis

Please see Figure 13 below which provides a visual summary of the key Lifeworld elements, in relation to being.

Figure 13: Being and Lifeworld Fragments



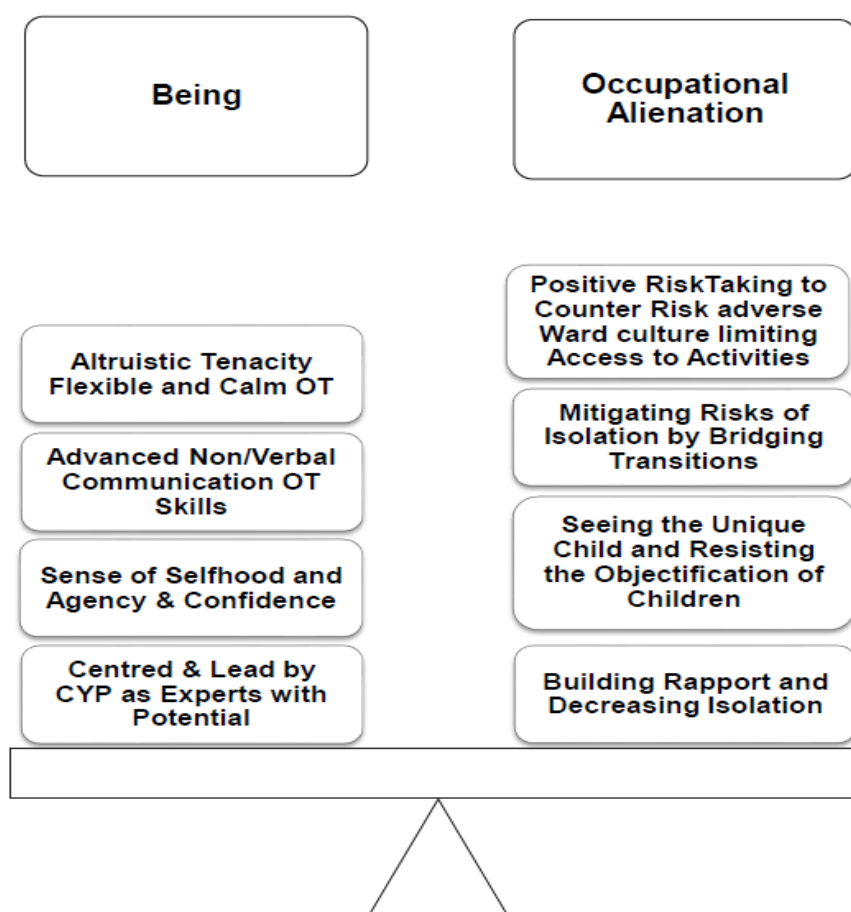
Occupational Alienation: Risks and Opportunities

Occupational alienation is defined within the OPH as a sense of disconnectedness and isolation (see chapter 2). The child may have a lack of identity or carry a sense of meaninglessness and have limited expression of their spirit (Wilcock and Townsend, 2000). The role of occupational therapy in addressing this for CYP with MH/LD, and countering disconnectedness, is as yet unreported. This study provides insight into how OTs described effective OT in this area.

Visual Summary of Being & Occupational Alienation

Figure 14: Being and Effective OT

'Being' and 'Effective Occupational Therapy' with CYP



Seeing the Unique Child & Resisting Objectification Children

The occupational therapists' project, or central activity, is to see the CYP as an individual with potential, not as a diagnosis. The move to resist the objectification of the child, prompted by the system view of the child, reflects an effort to address occupational alienation which can occur in institutional settings (McAnelly et al., 2015). The OT's principle role, or project, is countering the child's sense of disconnectedness and isolation, i.e. feeling of occupational alienation, especially for those with attachment difficulties. The occupational therapy role also establishes a consistent therapeutic relationship with empathy, caring and keeping promises. Professionalism is essential here above all else.

Building Rapport and Decreasing Isolation

The OT aspires to be non-judgemental, likes to spend time with the young person and focusses on getting to know their interests and what is important to them in order to decrease isolation, meaninglessness and disconnectedness. The embodied and social nature of occupational therapy appears to be an important factor in the child's development of being. The physicality of being together whilst doing different activities, and the OT getting on the child's level, decreases the risks of occupational alienation by reducing the sense of isolation and disconnectedness of the child. Effective occupational therapy deals with intrusive questions from children in a boundaried and professional way, recognising that such queries emanate from the child's sense of disconnectedness or isolation.

OT addresses disconnectedness and occupational alienation to establish consistent, meaningful and truthful relationships. Temporality is a vehicle used by OTs to convey commitment to engagement, build rapport and consistency of OT sessions, decrease isolation disconnectedness, and cut through layers of barriers holding children back from being able to participate. It can take considerable amounts of time and can never be rushed. The OT encourages the child to make a connection to the OT and the activity, with the threat of occupational alienation if commissioned services do not always allow the luxury of time and promotes a culture of rushing things.

Positive Risk Taking to Counter the Ward Culture of Risk Aversion
Limiting Access to Activities

In terms of the effectiveness of occupational therapy to develop a child's sense of being, positive risk-taking in OT appeared to counter a culture of risk aversion on the ward, resulting from having to manage high levels of behavioural aggression from the children. As such, occupational therapists were actively working to reduce the risks of occupational alienation for CYP by improving access to activities and occupations otherwise restricted, through careful and individualised risk assessment.

Mitigating Risks of Isolation by Bridging Transitions

There is a tension for OTs between maintaining a sense of stability for the child to discover their being, and the professional anathema of creating dependency. This apparent dualism surfaces where children have highly

disrupted lives and the OT role may be to provide stability to mitigate against the risk of occupational alienation, aiming for the CYP to maintain a sense of identity and connectedness in times of change. This internalised professional conflict surfaces where the role of OT in addressing occupational justice (Wilcock, 2007) issues is more intuitive than informed, (Mattingly and Fleming, 1994) and potentially misconstrued as (co-) dependency. Understanding the OT intervention as effective from an occupational justice perspective may enable OTs to provide a more coherent clinical reasoning for their actions and maintain any progress made thus far when children are faced with significant life transitions. Such an example raises the issue of models of clinical reasoning and the level of reflective insight and psychodynamic transference issues the OT is subjected to, whether they are professionally aware of it or not. Effective supervision to support effective occupational therapy was described by some as important in maintaining boundaries.

Summary

The thematic analysis identified four areas associated with being. When occupational therapy is most effective it is child-centred, with the OT encouraging the child to lead and be the expert in themselves, recognising the CYP potential. Key to developing occupational being with the child is to help develop a sense of self-hood, agency and internal locus of control. OTs use advanced non/verbal communication skills to engage and mirror the child, while putting them at ease so that they fully engage in therapy. OTs' ability to stay calm, and be flexible, enables occupational therapy to be effective, as does their tenacious determination to never give up on young people.

The OPH analysis pulled out specific elements of Lifeworld fragments, deepening the level of analysis and understanding of the phenomenon of effective occupational therapy with CYP with MH/LD, summarised metaphorically as:

“They’re the tree and we are the people that are turning the lights on for them to then sparkle”.

Four distinct areas of OT involvement to address occupational alienation were identified: building rapport and decreasing isolation; resisting objectification of the child and celebrating their uniqueness; mitigating risks of isolation by bridging transitions; and improving access to activities for CYP by countering risk aversion with an individually risk-assessed, positive risk taking approach. The next section will take the same approach to presenting findings on the OPH aspect of becoming.

Becoming and Effective Occupational Therapy

This section will analyse the findings of what effective occupational therapy with CYP is in relation to becoming, illustrated by examples from thematic data (see Appendix 19). A summary of Lifeworld analysis related to becoming will be presented in diagrammatic form, including an example from the discourse analysis. The discussion will then move on to the occupational justice risks and opportunities to address occupational deprivation.

Becoming and Thematic Analysis

The OPH concept of becoming encompasses the child's hopes, goals and aspirations (see Chapter 2).

Flexible, Adaptable and Fun

Effective occupational therapy is adaptable to how the CYP is presenting and what they are doing, ensuring success in using the environment and activities. Effective occupational therapy is creative, solution-focused and incorporates the fun, leisure side of things. Qualities of the OT include willingness and ability to change track, to be the container and the enabler, and being focussed that everything is for the benefit of the child.

CYP Assuming Responsibility

Occupational therapy facilitates the CYP to lead and have a sense of control that they will explore, empowering them to be an expert themselves and assume responsibility. The expertise of the OT is in not assuming an expert

position and, therefore, not worrying about articulating it. OT aspires to be non-judgemental and allows the child to follow their own wishes. OT is provided on a regular basis and starts and finishes on time. Supporting transitions for CYP increases their sense of control and focusses on potential and the future.

Assessing Motivation and Skills

Effective occupational therapy focusses on the CYP's motivation, while assessing numeracy, literacy, and social and communication skills. The role of occupational therapy is highly bespoke and individualised, with limited value afforded to standardised assessments which were reported as rarely capturing the child holistically. Where calibrated, they tended to underscore ability due to mental health and learning disabilities impacting on time-related testing, thereby conveying a greater level of problem than may be the case.

Enhancing Independence and Re/habilitating CYP

Occupational therapists primarily grade risk and encourage positive risk-taking to bring forth a young person's potential, thereby enhancing independence, emotional literacy and confidence. Occupational therapy focusses on rehabilitation, not dependency. It supports CYP to be independent, pushing them to take on new practical challenges, modelling skills and grading them to make it safe to enable them to succeed.

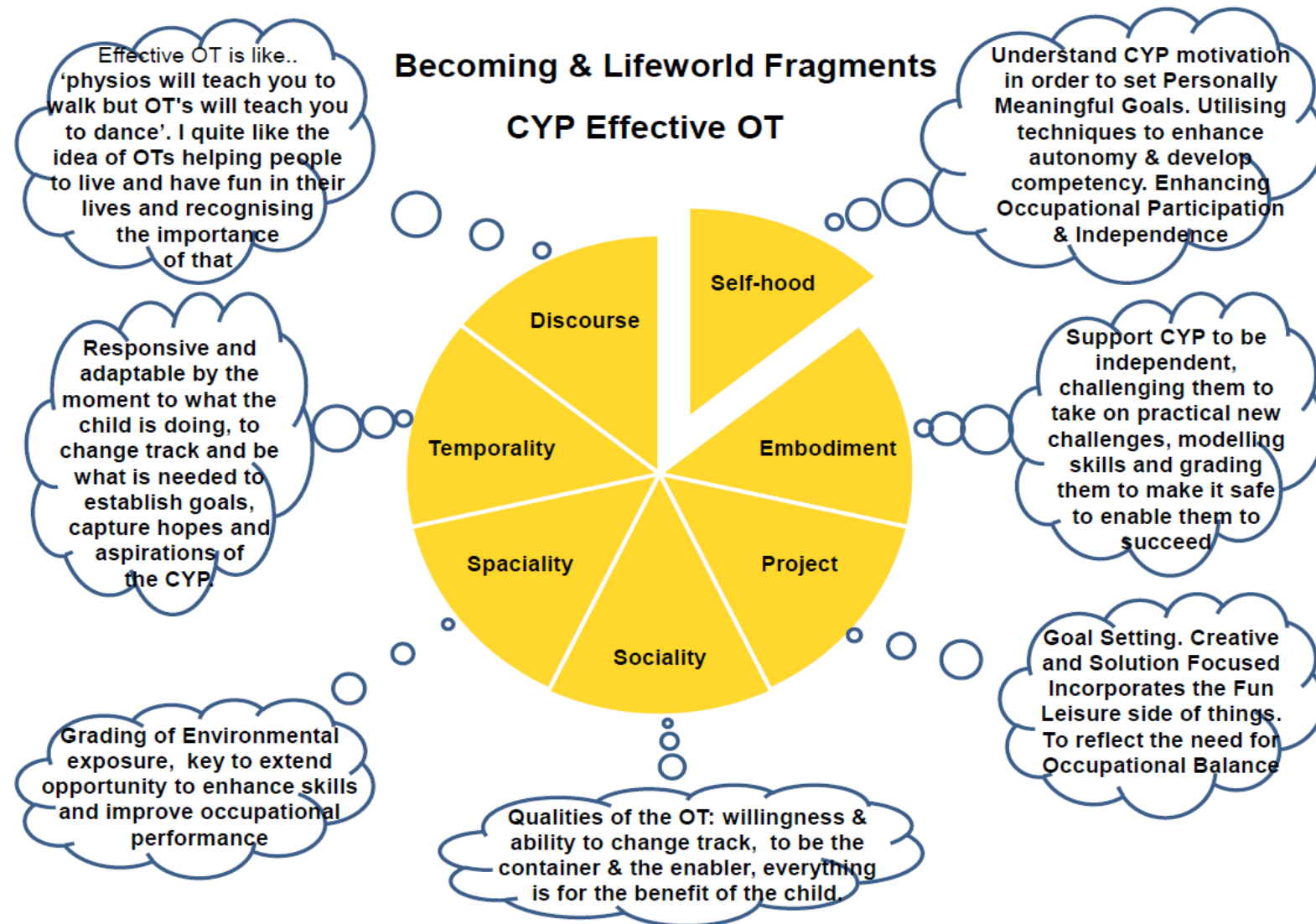
Becoming and Lifeworld Analysis

Analysis of the Lifeworld fragments of OTs, from the OPH perspective of becoming, enabled an ever-deepening understanding of the phenomenon under investigation.

Visual Summary of Becoming and Lifeworld Analysis

Please see Figure 15 below for a visual summary of the lifeworld analysis, in relation to becoming.

Figure 15: Becoming and Lifeworld Fragments



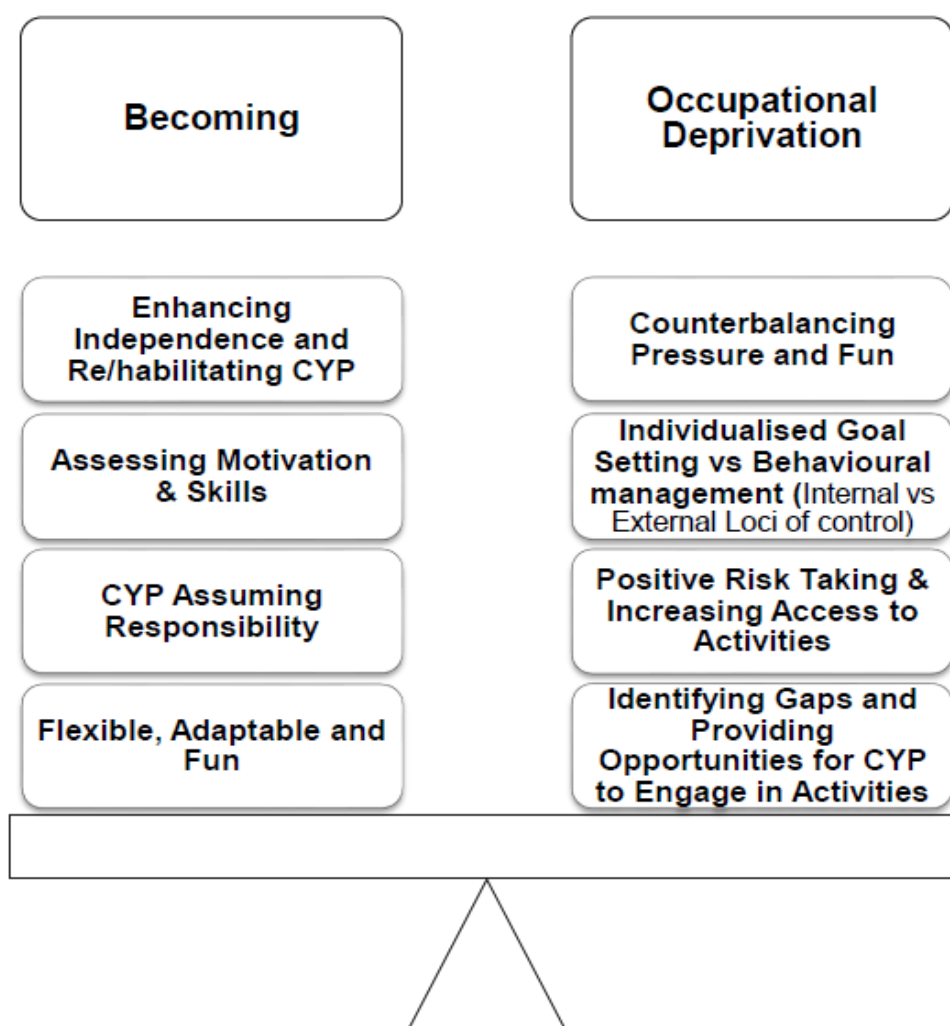
Occupational Deprivation: Risks and Opportunities

In keeping with the overview given below, the following section explores occupational deprivation, defined as prolonged preclusion from engagement, outside of the control of the person (Wilcock, 2006).

Visual Summary of Becoming and Occupational Deprivation Figure 16

Figure 16: Becoming and Effective OT

'Becoming' and 'Effective Occupational Therapy' with CYP



Identifying Gaps and Providing Opportunities for CYP to Engage in Activities

OTs identified gaps in opportunities available for children to engage in activities which were beyond their control. Addressing such occupational deprivations is a consistent aspect of occupational therapy practice, though rarely articulated in terms of being part of the OT role.

Positive Risk Taking and Increasing Access to Activities

The theme of positive risk taking to address issues of occupational deprivation was common within OTs working in inpatient units. Occupational therapy can make a difference to what children get access to on and off the unit within a system reported to be primed towards risk aversion. This can make such access negotiations difficult and often unsuccessful, deriving from a single OT voice within a nurse-led ward team. The impact of a child not having such an occupational opportunity has a less visible impact compared to that of a serious incident for a ward or hospital, having more visible and litigious implications where Health and Safety Legislation is concerned and CQC regulatory function for safety and potential for reputational damage to a service/organisation.

Individualised Goal Setting vs. Behavioural Management: Internal (OT) Vs External (Ward) Loci of Control

OT actively encourages CYP to push themselves to identify their hopes and aspirations, and extend their life skills to meet them, through collaborative and

dynamic goal setting. The occupational therapy philosophy of supporting people to become more occupationally satisfied in their lives and setting related goals is in contrast to behavioural management approaches taken on wards, which contain disruption and seeking compliance through the giving and withdrawal of occupational opportunities outside of the control of the child.

Collaboratively working together (sociality) in occupational therapy identified a task of navigating through systems that may not see the child or meet their needs. Where occupational therapists identified that the system needed to change, they made concerted efforts to empower the child in such systems (ward rules, nursing staff, MDT) or help work around it by addressing issues which were outside the control of the young person. OT identified issues related to the speed of change for CYP and advocated for a slower tempo of change on the ward to increase the child's control.

The rules-led environment of the ward contrasted the empowerment experienced in OT sessions, itself requiring an intervention to help straddle the variation in levels of occupational deprivation associated with them. The contrast between the loci of control being internal in OT sessions was compared with the external locus of control experienced on the ward, where rules and authority emanate from nursing staff:

“Not a lot of young people have a lot of control in that place”.

Particularly noticeable is that this study focussed on effective OT and not effective nursing/team/behavioural approaches. From non-OT perspectives, OT could be viewed as undermining a system-based behavioural management approach and creating behavioural problems. One example was provided of a

young person struggling with the transition from one environment to the other, demonstrated in self-harming behaviour, which the OT herself reflected on with concern and was later redressed through an MDT solution to the transition between environments.

OT recognises times of transition (change of school, etc.), with the resultant changing expectations of occupational performance, and reviews goals and aspirations to consider different future occupational roles, with the related need to address the potential occupational imbalance and address skill and competencies related to becoming, or to re-establish balance.

Counterbalancing Pressure and Encouraging Fun

Other aspects of the OT project were clearly related to promoting a counterbalance to the pressure and questions asked of the CYP and the lack of fun on the wards, this being described as easily forgotten about. Occupational therapy recognised some systems were disempowering for CYP and offered interventions which supported the child's self-hood through encouraging them:

“You can and must direct your own treatment plans and care.”

Summary

When occupational therapy is most effective, thematic analysis identified four key areas associated with becoming: OTs being flexible, adaptable and encouraging fun; encouraging CYP to assume responsibility for their lives and set personally meaningful goals; assessing motivation and skills required to meet future goals; and seeking to enhance independence through re/habitation.

The OPH analysis pulled out specific elements of Lifeworld fragments (OT setting meaningful goals, encouraging occupational balance, being responsive to the needs and hopes of the child), thereby deepening the level of analysis and understanding of the phenomenon of effective occupational therapy with CYP with MH/LD. This is summarised metaphorically as the difference between walking and dancing, where OT recognises the importance of living and having fun.

Within issues of occupational deprivation, OTs identify and address gaps in the provision opportunities for CYP to engage in activities. They encourage positive risk taking following careful risk assessment and seek to increase access to activities. Effective occupational therapy facilitates individualised goal setting and the development of an internal locus of control (Poulsen et al., 2015) which may contrast systemic dynamics which lean towards behavioural management approaches and an external locus of control.

Belonging and Effective Occupational Therapy

Results of the analysis of data from the perspective of the OPH concept of belonging (which encompasses the child's sense of connectedness discussed in Chapter 2), will be illustrated with examples from thematic data. A summary of Lifeworld analysis related to belonging will be presented in diagrammatic form, including an example from the metaphorical discourse. The discussion will then move on to the occupational justice risks and opportunities to address occupational marginalisation (as defined in Chapter 2).

Belonging and Thematic Analysis

The following three themes emerged from the OPH analysis, related to belonging:

Establishing a Therapeutic Relationship

Data analysis identified the OT's central activity as being focussed on establishing the therapeutic relationship and engaging with the child and, by so doing, enabling a sense of connectedness. OTs accepting the child, who they are so that they feel safe, speaks to the primary initial connection between child and OT. Connectedness with the environment and a familiar occupation was noticed by the OT through the child's words and facial expression/body language.

Facilitating CYP Emotional Connections and Agency

Occupational therapy facilitates the development of the child's self-hood with an increasing sense of self-connectedness, seen when children express how

they are feeling, as an autonomous choice to do so. Citizenship is a mark of belonging, and becoming involved in groups and CYP thinking about what they can contribute appears to be a strong indicator of occupational wellbeing and a mark of significant progress from the OT's perspective.

Facilitating 'Family' Connections and Agency

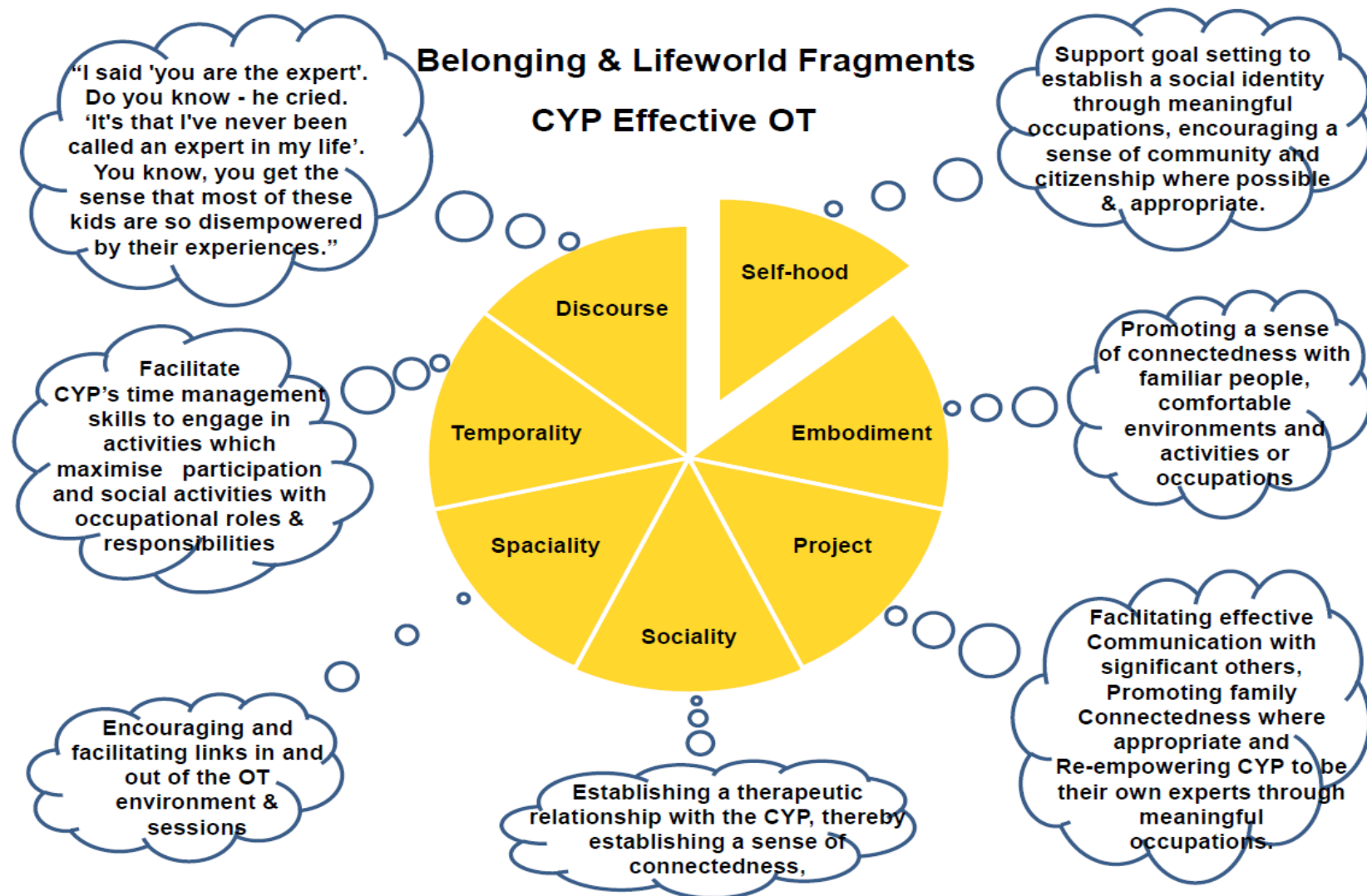
The function of facilitating connectedness is evident in occupational therapy, thus bridging the gap of parent and child communications. Promoting family connectedness was an explicit aim in some occupational therapy described as effective, re-empowering the family unit to trust their own solutions and expertise, highlighting a function of occupational therapy in facilitating an internalised locus of control (sense of agency), whether on an individual or family basis. Occupational therapists identified substantial progress happening when children involve significant others (family, friends, MDT therapists and peers) to help achieve or recognise progress towards their goals, reporting back to tell the OT about what had been done and demonstrating a sense of connectedness.

Belonging and Lifeworld Analysis

Visual Summary of Belonging and Lifeworld Analysis

Please see Figure 17 below for an analysis of belonging and the Lifeworld fragments.

Figure 17: Belonging and Lifeworld Fragments



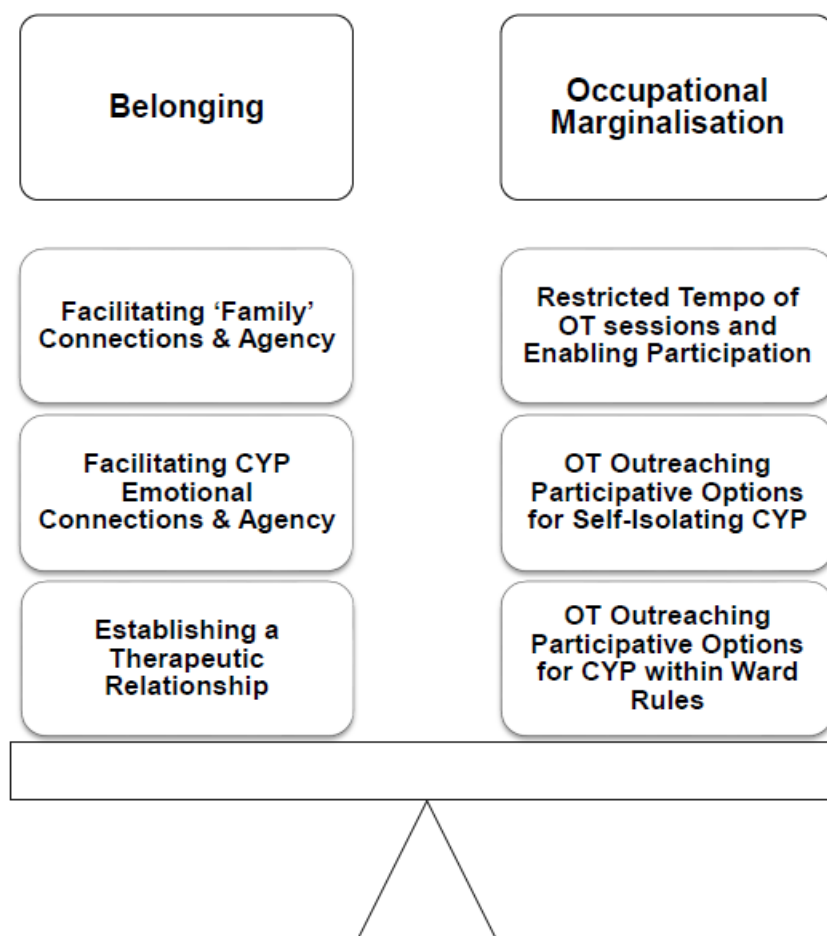
Occupational Marginalisation: Risks and Opportunities

Occupational marginalisation has been described as one of the more invisible occupational injustices, as it is often hidden in normative standards which dictate where, when and how people will or should participate.

Visual Summary of Belonging and Occupational Marginalisation

Figure 18: Belonging and Effective OT

'Belonging' and 'Effective Occupational Therapy' with CYP



OT Outreaching Participative Options for CYP within Ward Rules

In-patient units necessarily have routines and systems for organisational purposes. However, examples were given where CYP would be excluded from participation as a result of breaking ward rules, e.g. time in seclusion (in a low stimulus room on their own, modestly equipped with high specification fixed fittings, to minimise risk of self-harm) due to challenging behaviour.

OT Outreaching Participative Options for Self-Isolating CYP

Similarly, and more commonly, children isolated themselves, by staying in bed or their bedroom, often as a function of their MH/LD condition. Wards having rules requiring CYP to get up/out of their room, or not having such rules due to human rights legislation, could constitute hidden normative standards that preclude participation i.e. occupational marginalisation.

OTs described bringing activity choices into bedrooms, encouraging children out of bed and bringing activities into seclusion-like quiet rooms. Endeavouring to bridge occupationally marginalising practices and enhance participation. Different rules within the OT department compared to those within the ward environment did cause some CYP significant issues as they slowly processed the transition to a more authority-, rules-led environment from the empowering one of OT.

Restricted Tempo of OT sessions and Enabling Participation

It could be argued that the temporality focus and pattern of delivery in OT, providing a one-hour session once a week, is a dictate of how and when OT

will be available. Given that OT often enables access to areas which are otherwise off limits, the pattern of OT provision could in itself be occupationally marginalising. In the broader context, most respondents described occupational therapy as being part of a programme of activities, including educational provision, so although the level of participatory impact may be mitigated it is worthy of note.

As with all occupational injustice categorisations, the duration of exposure to them is a factor in how much impact they have, along with many other factors such as personal resilience. In a ward situation of vulnerable young people having limited freedom of movement, the rules allowing access to environments and activities are contentious and, where identified as an issue (i.e. identified as 'blanket restrictions'), are regulated by CQC (Care Quality Commission, 2016c) and reflected in QNIC national standards, as requirements of good practice.

Summary

When occupational therapy is most effective, thematic analysis identified three key areas associated with belonging: establishing a therapeutic relationship; facilitating the child to make emotional connections and have agency; and facilitating family connections. The OPH analysis summary illustrated specific elements of Lifeworld fragments such as goal setting to develop a sense of community and citizenship, facilitating communication and activities with significant others, time management and organisational skills for occupational roles and linking in/out OT sessions. This has enabled greater levels of

analysis and understanding of the phenomenon of effective occupational therapy with CYP with MH/LD, summarised metaphorically as the child as the expert.

When addressing issues of occupational marginalisation, OTs provide an outreaching function to increase the participation of CYP where ward rules or the child's own self-isolating behaviour significantly impacts on their opportunities to do things with others. Paradoxically, the pattern of OT provision (average weekly, hour-long sessions) may be seen as occupationally marginalising, if it is fundamentally the gateway to most activities, either by environmental access or access to choices of activity and occupation. This was highlighted by over half the respondents describing CYP as demanding: more OT sessions; or when the OT will be back from holiday; or forward planning access to OT during summer months when educational classes were not on; or not wanting OT sessions to end for fear that they would not happen again.

Occupation

Hocking (2009) called for occupational science researchers to separate the reporting of occupational performance (the doing of occupations and how they are experienced) from occupation (occupational forms). Whilst this research did not specifically seek information on any one occupation, there was a significant level of description given to one: that of cooking.

Hocking's premise that one occupational label may hide a plethora of variation in that descriptive label was reflected in this study in the phenomenon of cooking. It is included here for completeness and also for the light it shines on the variation in the occupation of cooking within the field of MH/LD CYPS. Hocking suggested eight categories for structuring feedback, which will be used in this high level analysis.

What is Cooking in CYPs?

Cooking is a term which is given to anything that happens in a kitchen environment. It usually has an end product which is enjoyed after the OT session, either alone or more often shared with others. Mostly, the focus is on the process more than the outcome, the acquisition of skills, and the contribution it has towards the CYP goals and aspirations.

With Whom & When

Sessions are mainly one hour in length, usually with a young person and an OT, and repeated weekly at the request of the child. Most examples come from

hospital settings, though cooking was also described in the community, such as in the young person's own home.

What? How? Where? Using what?

The aims of the cookery session are as broad and individual as the children who choose to engage in that activity. The following are a range of cookery sessions described as part of effective OT sessions: cooking cakes, preparing cold snacks, carefully preparing sushi without feel scrutinised, cooking easy meals from jars and packs of pre-cooked foods, and preparing complex Indian curries using spices and raw ingredients.

This also included regressive play, as one boy started playing with a jet of water in a kitchen sink, resulting in him describing past holidays with his father playing in Saudi Arabian fountains. It also included making Grandma's Lardy cake as a tribute to her recent passing and acknowledging the grief of a young girl for whom she had been a replacement mum. It also became a paper-making factory in a marbling art session which heralded a young woman getting out of bed for the first time in three days and re-establishing some control in her life. It was the finishing part of a cooking session which started at a young person's bedside who could not leave her room, but had cookies baked and returned by the OT for her. It was described as being akin to a surgeon's operating theatre, where a young person was trying out different ways of being and asserting herself. More often it was a place for a young person to make a cup of tea and have a chat, seeking support and enjoying not being coerced into self-disclosure. The process also included having time out, or a reprieve from a demanding ward environment.

Capacity, Knowledge, Skills

The principle skills required for cooking with CYP is the belief and attitude that there are no hard and fast rules governing cookery. Effective OT sessions in the kitchen hinges on the OT's capability to flex and bend to the CYP needs, and provide a space within which the child can meet their goals whilst maintaining a safe and secure place. Often parallel processes are occurring where the CYP is overtly focussed on a particular activity and making something they are motivated to do, whilst the OT is covertly grading and adapting the environment, activity, and the person. The OT is assessing skills and pre-empting safety issues simultaneously to facilitate the child to achieve their goals. Often CYP were described as having good level of skills in the kitchen and future research could investigate this further. Clearly OTs themselves must have reasonable levels of cooking skills and be comfortable in such an environment in order for the CYP to get the most out of and feel comfortable in it.

Outcomes

Often there is a tangible, material outcome of food to share, which has cultural value in a ward environment where hospital food may not be exactly what CYP want. The intangible or hidden outcomes are likely to be in the areas of self-hood, agency, skill acquisition, sociality and tolerating an embodied experience with another adult.

Meanings and Standards

The less tangible elements of cookery are the interactions and conversations between CYP and the OT. These include negotiating movement and body proximity around a limited space and sharing a lot of time together, within which much is negotiated, shared, learnt and enjoyed. Also important is the shared space and negotiations of starting and finishing on time, rules of safety and negotiating tasks of cooking, tidying, completing the task, negotiating the sharing of the end product with other young people and the meaning which cooking holds for the CYP.

Context: Sociocultural; Political; Economic; Historical

As stated earlier, the research aim was not to analyse cooking, so this analysis is necessarily high level, but still touches on previously-mentioned occupational injustices experienced by CYP living in a ward environment, where access to a kitchen environment is restricted. Availability of and the opportunity to go out shopping for ingredients will be restricted to times when CYP can be accompanied to go out, transport is available and funds are in place to buy ingredients.

Impact on Health

Interestingly, CYP in such environments usually have a reasonable disposable income (pocket money) with few opportunities to spend money. Spending on food allows them some control over what they consume in an environment where there are limited choices compared to the takeaway options available

at home. Hospital food is regulated for its nutritional value and compliance with expected standards to protect CYP from ill health due to diet. In addition, public health concerns about childhood obesity and reduced opportunity to exercise whilst on a ward make such food intake and personal choices contentious issues. Making unhealthy choices may improve agency and self-hood, but also negate the hospital responsibility to protect CYP from harm.

Summary

Hocking's aim with the proposed structure for reporting on occupational forms such as cooking was to encourage occupational scientists and OTs to build a more granular lexicon of the culture of occupation, beyond traditional categorisations of work, self-care, and leisure. By understating the skills, knowledge, capabilities and attitudes required to participate in an occupation it might be possible to create repeatable experiences or conversely recognise an occupational as unique. This research has identified cooking as a highly valued occupation, which serves a multiplicity of functions both for the child and the OT.

Conclusion

This chapter examined effective occupational therapy with CYP, using an Occupational Perspective of Health (OPH) to address the fourth research objective: to interpret the meaning of the lived experience of effective occupational therapy within the OPH. Whilst there are differences between the terms participation and occupation (Wilcock and Hocking, 2015), it is important for young people to have meaningful occupations which enable them to fully participate in society, whether in hospital or at home (Ziviani and Rodger, 2006).

Consequently, an Occupational Perspective of Health (OPH) was used to analyse the data and has undoubtedly provided an additional granularity and relevance as a conceptual framework by which to understand participation in relation to effective OT with CYP. Responding to Hocking's call for clinicians to consider the framework and note the difference between occupational performance and occupation, results have been reported in terms of occupational performance (doing, being, becoming and belonging) and occupational form (cooking).

The thematic and Lifeworld analyses were coded against the Occupational Perspective of Health with the analysis of findings using the OPH to guide this discussion focussing on: Doing & Occupational Imbalance; Being & Occupational Alienation; Becoming & Occupational Deprivation; and Belonging & Occupational Marginalisation.

The results have been reported and illustrated in various ways to capture the range and depth of insights gained from this additional level of analysis. Through this systematically applied method, the conceptual extrapolations are

grounded in the primary research data and contribute to the veracity of the conclusions drawn. This analysis progresses the journey of an increasingly interpretive process, as insights are gained and built upon in an ever-deepening understanding of the meaning of effective occupational therapy.

Chapter Eight: Reflexivity

Introduction

As outlined in the Methodology Chapter a reflexive relational approach was used throughout this study. Finlay suggests that the researcher influences the research through their position, perspective and presence (Finlay, 2002b). Consequently, this analysis will cover the three phases identified by Finlay: pre-research, data collection/gathering and data analysis. Evidence will be presented from source material including transcribed researcher diaries, project documents, university submitted supervision records and participant transcripts.

Reflexivity is seen (Finlay and Gough, 2003) as a useful tool to gain insight into the impact of the researcher themselves, and to empower others via evaluation of the process and enabling public scrutiny. It is an exploration which, in essence, allows the reader to effectively scrutinise underlying motivations and acknowledge any researcher bias. The traditional concept of reflection is post-event, a more distant thinking about what has occurred, whereas reflexivity here captures a more dynamic, contemporaneous element of being self-aware, in the moment and thoughtful.

This reflexive account is the synthesis of insights gained over the duration of the past four years, which aimed to maximise the learning from dynamic in-the-moment observation of research processes and content from pre-research, through data collection/gathering and analysis, to beyond the study and changes in practice. Acknowledging the 'muddy ambiguity' of such evaluations, Finlay (2002a) offers a conceptual map for qualitative researchers, highlighting five of the principle types of reflexivity: introspection,

intersubjective reflection, mutual collaboration, social critique and discursive deconstruction. Through successful navigation of the reflexive terrain, Finlay posits that researcher presence becomes an opportunity rather than a problem.

Given the focus on Lifeworld within this study, consideration was given to Greasley and Ashworth (2007) suggestion that the learner use Lifeworld fragments in order to structure a more transparent account of what the acquisition of knowledge means to them. Methodologically, however, Lifeworld analysis by definition requires that it captures a pre-reflective state. The researcher, having engaged in years of reflexivity as a considered methodological element of taking a reflexive relational approach, was unable to satisfy this requirement and consequently the more analytical model offered by Finlay has been adopted as epistemologically and methodologically congruent with the overall approach of the study.

Consequently, the researcher diary 2012-2015 was transcribed and analysed using the five reflexive domains suggested by Finlay (2002a). Using in NVivo software, the material was coded and correlated, and excerpts from this and other written materials, such as transcriptions and supervision records, were drawn upon to illustrate the embedded nature of the reflexive process within this research study.

Critiques of the use of the reflexive account highlight issues of infinite regress (Finlay, 2002b) and narcissistic tendencies, which do not progress the aims of research. Consequently, the aim of this reflexive account is honed to avoid such pitfalls: to increase the transparency, trustworthiness and accountability

for this research; to focus on the research participants and endeavour to increase understanding of the phenomenon under investigation; to review reflexive endeavours in the light of research aims and focus; and to identify any key issues and present them in a creative way.

The following reflexive account will provide evidence to support the reader to assess each of Finlay's guidelines (Finlay, 2002a) to appraise this research.

A Visual Representation of Reflexivity Discussion

Figure 19: A Visual Representation of Reflexivity Discussion

Table of different phases and headings using model of assessing trustworthiness:

	Intro- spection	Social Critique	Inter- subjective reflection	Mutual collab- oration	Co-Con- struction	Discursive Decon- struction
Pre- Research	✓	✓				
Data Gathering	✓	✓	✓	✓	✓	✓
Data Analysis	✓	✓		✓		✓

Pre-Research Phase

Whilst the area of interest of this study has remain consistently focused on children and young people with mental health, the motivation behind the specific area of enquiry has undergone significant transformation.

Introspection

The challenge of using the reflexive skill of introspection (Finlay, 2002a) is to use personal insights not as the ultimate goal but as a platform for more

general insights and interpretations, overtly linking claims of new knowledge with experiences of those involved in the context within which they operate.

The original research proposal was entitled “Occupational Therapy, CAMHS (Child and Adolescent Mental Health) & Outcome Measures: The Development and Pilot of an Implementation Strategy” dated 29th April 2013, and included the following aim and reflexive account explaining the researcher’s insider position:

“This study seeks to understand why occupational therapists (OTs) working in child and adolescent mental health services (CAMHS) are not using outcome measures (OMs) to convey the clinical effectiveness of their services.”

“I have reflected on my insider researcher position and applied Linda Finlay’s call for reflexivity and “coming out” in terms of the researcher position). I have specialised as a CAMHS OT for the past 22 years and undertaken Masters level research into the clinical reasoning of CAMHS OTs in order to improve clinical effectiveness. I consider OT to be an important intervention to aid the recovery and well-being of children YP suffering with MH problems. I have a strong drive to improve practice, having specialised in the governance of the profession for over 15 years, and for OTs to be as clinically effective as possible and to make the biggest difference to children and to focus finite resources efficiently. My drive is for effective marketing of OT & identification of their USPs. It is important that OTs recognise the importance of clinical reasoning to what they offer and draw upon evidence available to ensure best practice.”

The elements described were a drive to; improve practice, efficiency, effective use of finite resources, and create unique selling points and marketing via a managerialist perspective (Brown and Crawford, 2003), which had a significant impact on the original thinking around the area of interest and how to seek knowledge about it. The epistemological tension in the original proposal between exploring the lack of use of positivistic outcome measures versus a participatory approach to engage clinicians in the research was highlighted by

examiners and led to a significant re-consideration of epistemology, methodology, the research aim and question.

Social Critique

Finlay and Gough (2003) described the social critique element of reflexivity as a tool to explore and manage power differentials within the research process. There was a significant personal transition from being a professional manager, concerned about commissioners and wanting OTs to be more compliant in providing pertinent evidence to them, to being a professional doctoral researcher concerned with hearing the silent voice of CYPs OTs in its entirety.

On 18/11/2013 a research diary entry highlights:

“There has been a subtle change in my own identity from manager to researcher, hence a change in the research question from why not using outcome measures to wanting to understand the deeper issues behind clinical effectiveness in children services.

The shift from objectifying the CAMHS OTs, as a non-compliant group, and from the researcher as expert in knowing what needed to happen, to seeing greater complexity and the OTs as experts in helping to uncover such “deeper issues”. (See Appendix 8: Q1 for more detail).

Following a mentoring session on 17/2/2014 (See Appendix 20:Q2), the following outcomes were recorded in the research journal:

“Personal actions:

- be critically reflective of my role and impact on methodology
- relaxing my leadership muscles, query long-term strategic academic future
- differentiate the role of manager and get closer to Maria
- could I look at outcome measures questions as part my manager role now
- use outcome measures as background research question
- choose questions further from the manager role to increase differentiation between roles”

Following a written reflexive account on 19/2/14, (See Appendix 8:Q3), the following action was recorded:

“Task: to get good at being reflexive, consider how to use metaphor in my research diary, what are my political motives when I'm being a researcher and not a manager?”

As a consequence of the social critique and introspective reflexive processes, the study took a more empowering turn, with a revised research question, epistemological approach and methodology, all of which attended to power issues in role confusion, a strengthening identity as a researcher and the part that research has in influencing others.

Data Gathering Phase

The data gathering phase called upon all 5 of Finlay's elements of reflexivity: introspection, intersubjective reflection, mutual collaboration, social critique and discursive deconstruction. The examples given to illustrate this process.

Inter-subjective reflection

This calls upon skills to explore meanings emerging in the research process. The methodological choice to assume a reflexive relational approach (Finlay and Evans, 2009) utilises the concept of collaborative enquiry where data is co-created and focuses on relational components where reflexivity is central to the process. Examples from interviews (See Appendix 20: Q4, for full text), show this process in action:

Emily (OT): "Sometimes they feel like they're stuck, don't know where they are going... She paced constantly, so you see in this big gym, a teenager played skittles which involved me having to set up these ridiculous plastic things (skittles) which fall over at the drop of a hat..."

MQ: "Been there, done that!"

E: "I set them up in the shape for her to fire the ball, to whack them down and then pace. I set them up again and that went on for some months we offered twice a week which, for what felt like an eternity of putting these stupid little skittles. I can see them now, I can feel them. There are like embedded in my cells in my hand. And I was able to say to her how frustrating that was and how, it didn't seem to have any purpose. I put them up. She knocked them down. I put them up, she'd.... It just felt like it was dark in this cycle and that we couldn't move and then it made no sense and I didn't understand it.

...

MQ: "It strikes me as quite an altruistic act in the end. I've had those kids whack those skittles over, you know it's just so heart rendering, it's so soul destroying, it feels like that at the time doesn't it? What is this all about?"

E: "It is, isn't it? It goes on forever; you look at your watch, another 2 min (laughing)..."

MQ: "(laughing) It makes you laugh a lot because I remember that feeling so much, but there is something about this level of perseverance that seems...feels so important...there's something that is more important than you escaping."

E: "Completely."

Berger (2015) described the benefits of the *been there, done that* insider position, which include understanding nuanced reactions (shared laughter), and this excerpt shows the resonance of sticking with the child even though the activity is personally uncomfortable for the OT. The shared story and experience brought out the themes of altruism, stuckness, embodiment, perception of time dragging, contrasting with the therapeutic breakthrough of understanding for the child, highlighting the importance of endurance and perseverance in occupational therapy.

Mutual collaboration

The following example from Dianne (See Appendix 20: Q5, for full text), provides evidence of collaborative endeavour between researcher and participant. The aim here was to elicit a metaphor to summarise the views of the participant:

MQ: "At some stage I'm interested to know if you feel like there is a metaphor or a picture that might sum up, when occupational therapy is really effective, you know... That's like what? Does it illicit a thought or a picture or a metaphor for you?"

Di: "I keep thinking of a rollercoaster, because that's how I feel about working with kids, it is when you actually connect with them and you can see the change, it's absolutely amazing. It's just, the best feeling ever, when you make that connection and you can see progress ...but then the low bit is kind of really quite horrific in managing the kind of dynamics around working with children and the emotional processes, the risks, the legal system around kids. ...you know, the research is there, risk and resilience theory, why aren't we investing in children? ..."

MQ: "Is there anything out about the rollercoaster...you know when you think about that rollercoaster ..has it got any other things about it?"

Di: "I think it's got something around it like a container, ...

So I see it as a rollercoaster with a big kind of container around it which would kind of keep you safe while you're working."

MQ: "So, it's a rollercoaster... you can see it easy through the container. If you saw the rollercoaster in the container would I see the rollercoaster? or ..."

Di: "Yes, you probably see the rollercoasters and I think you'd see, just like an aura of film you know something to keep everything in there, you know if you are not able to be contained in amongst to the highs and the lows, by all means celebrate the highs with the families and the kids, you know you can share the progress, but if you can't contain the lows, it's not helping anybody. Families need you to be their container, so you need someone to contain you doing that work."

Co-Construction

This co-constructed metaphorical description of effective occupational therapy elicited the importance of containment for both family and therapist, as well as the unexpected concept of effective therapy being the containment of lows. Tensions for the researcher lay in using Clean Language techniques within an interpretive phenomenological methodology that requires the bracketing of knowledge/theories to enable the phenomenon to be seen afresh, with no pre-conceptions. The rationale for use of clean language lay in the philosophy behind it, which is to facilitate understanding/insights without imposing one's own language.

Social Critique

A social critique during the data gathering phase considered power imbalances by virtue of the managerial/leadership role of the researcher. The invitation and organisation of sessions was managed by a third party (researcher administrator), and emphasised ethical considerations, which were thorough and included in the participant information sheet and consent form signing process. Despite all these strategies, there were a number of occasions when positional power and an internalised critical voice was alluded to by participants:

“That younger person was quite comfortable being silent. I found that really extremely uncomfortable, because I felt the pressure. I thought “if XX saw me sat here being quiet for 60 min, what's the therapeutic value of this? (laughing), so it's about going easy on myself really and I think

that's about your own core beliefs, putting pressure on yourself and making sure that you're doing the best job..."

Another hint of the participants' awareness of positional power or performance anxiety came at the end of one interview:

M: "So full circle to what's to makes you tick, and to the thank you card, and it is the outcome for the child. Are you happy for us to finish?"

Cathy: "I hope that was all right?"

M: "Of course."

Introspection

An example of introspection both during and after the interview (See Appendix 20:Q6, for full text), was shown with Bernadette:

"29/10/2014 (Int 2) Bernie. Post interview researcher notes.

There appear to be themes around positive risk-taking as well as highly graded risk assessment. The OTs communication style seems to be key and the drive to be consistent along with use of both verbal and non-verbal methods of communication and creative methods in activities. The OT appears to hold hope for the child and others. The key positive or assessment of effectiveness appears to be when the child makes links between sessions and people to linking in and out of sessions. There's the concept of OT time and privacy and dignity which appears pivotal. The opportunity for the child not be scrutinised checked ...

I asked questions around age of diagnosis which was my own need to be able to understand the problems within my previous schema and was an example of when I was struggling to bracket to my previous knowledge and understanding and interestingly this appeared to reflect a dynamic with the ward – where the ward sees the child's diagnosis and the problems, whereas the OT is seeing the child and the solutions."

The reference to bracketing shows evidence of an active consideration to 'hold in abeyance', previous understandings. This observation was offered during the interview and led to an affirmation from the participant that ward staff similarly objectified the child through focussing on their diagnosis, rather than

their individual world. This observation could then be reflected on in terms of recommendations following analysis.

Discursive Deconstruction

Evidence of discursive deconstruction (deconstructing a concept/idea as part of a discussion) is drawn from the interview with Emily, which started with eliciting a metaphor and led to a collaborative exploration of the meaning of the embodied feelings the OT would experience in sessions. (See Appendix 20: Q7, for full text),

MQ: "That something important has happened when you feel it in your heart has that got a size or shape or colour is there anything about it. Has it got certain attributes?"

E: "It feels like a heavy feeling but I don't know why, you'd think it would be a light happy feeling. But it's heavy because it's important solid...solid. It feels like a solid circular kind of spherical shape you can just feel there. And it's red, I don't know why it's red. I can feel this red sphere... just here.

It's static that you'd think it would flutter or beat or move or something but it's just a solid, round solid shape...

Not really no, it's just, I don't know. It feels like... This is really hard. I've never even thought about this before but I can picture it now you've taken us to it.

I think it's solid rather than light and airy and happy. it just feels like it's something really big and important, something you can grab a hold of, is like physically there. Grounded sense about it. Maybe it's something to do with, you now there's been some breakthroughs or understanding of what's happened and it feels like you've made some kind of solid connection or sense of what is maybe that's why it's a solid shape. There's something quite grounded, some sort of evidence of what you think of what you feel. Don't know..."

MQ: "What comes just before that solidity?"

E: "That, you breathe it in, and then it's there, you get goose pimples and then you just feel it. There, just below your heart."

MQ: "How does it feel evoking it?" (*I was annoyed with myself at the time, for asking a loaded question, instead of keeping with clean questions*)

E: "It's neither nice nor uncomfortable. I don't know Maria, it hasn't got a negative attachment to it but it's not like all happy and joyful either because it is sometimes what, sometimes the reality of what you're feeling sometimes this isn't nice, it isn't a nice thing. ..."

Data Analysis Phase

Introspection

"I asked occupational therapists to describe situations ...I asked for as much detail of possible of what was actually happening at the time (Finlay, 2011)... Specifically, about the environment (where/when), behaviour (what was happening in the room/what was being said), as I was interested in whether the OT would describe using particular OT skills and professional values/beliefs which might underpin their practice".

Introspection and Embodiment

"My first sweep of the data is in order to understand the participant's perspective what they are trying to say what does this mean? This commenced with transcribing the interviews myself using Dragon NaturallySpeaking and repeating every word of each interview. I felt like the words were flowing through my being, it was a very moving process hearing the wonderful stories of very unwell children who had been helped by OTs. This embodied feeling was also part of my reflection, as the Reflective Relational (Finlay and Evans, 2009) approach to data collection, encourages an awareness of embodied responses and what might be projected by the participant. The concept of embodiment is also encapsulated within Ashworth's Lifeworld approach to data analysis, an approach I will also be taking..."

MQ Diary a research memo in NVivo January 2015.

Discursive deconstruction

The best example of discursive deconstruction at the data analysis stage is through the supervisory process, where emerging codes and ideas are

discussed and challenged. An early example was around the concept of effective occupational therapy: what is effective? how is it defined? This conversation was extended into a writing retreat, which eventually led to an introspective reflection resulting in a clearer explanation using regulatory frameworks to explain that clinicians use the term effectiveness all the time, without debate, whilst academics hearing the word have an almost visceral academic shudder, a palatable distaste for the word. I suspect the underpinning academic discomfort is with the embedded paradigms and politics of how healthcare orientates certain outcomes on grounds of limited financial resources, cloaked in a shroud called effectiveness.

Social critique

Di: "We pour money into adult mental health but it's too late. We actually should be pouring the money into children's services. Because actually if we get that right then we don't need as much of the rest of it and it makes and that's the lows for me, having to compromise for what's right for kids when, actually... I'm in quite a protected service, when I hear my colleagues talk about life in the community; I still fail to understand how it's got to this. How we place so little value on child mental health."

MQ: "Yes."

Di: "You know it's national it's in the press is not enough beds. There's not enough care, when actually you've got to invest in the children's services in order to shape the development of our future population. I don't understand why it's not happening, that's the low..."

Mutual collaboration

Here the participant and researcher share (See Appendix 20:Q9, for full text), the uncomfortable experience of time distortion in OT, leading to greater honesty of the OT to say she did not know what she was doing:

MQ: "You are saying about being really tuned into the non-verbals. I remember sessions, I can't imagine how that felt for you over a long period of time because I remember sessions with children that were mute, and it's actually excruciating - one hour's session would feel like forever."

F: "Yes, it's painful."

MQ: "Yeah, yes a 10 minutes session can make you feel really uncomfortable."

F: "It makes you think of your observation skills and about taking you back to your roots. ... I felt really stuck with this young person. And that's my anxieties and expectations and put onto the young person and trying to move them on quicker and and that's my personality traits. I want job done, right move onto the next one. It's made me look at my own clinical skills and I've had the richness of working with her for a couple of years. I've had a lot of time to think about her

MQ: ..That position when you're thinking this is feeling very uncomfortable to being quiet and a silent session, and you describe that and I can recall that from my practice, and you kind of think, that over the extended period of time. All the questioning, self-questioning that you've gone through, ...

F: "Yes, I have come away to the team, they have been a great support, because it's a safe place to be able to say "what the chuff am I doing?" (laughing) How many times will I have to get cards are making materials? It's exhausting, it is absolutely exhausting. But you kind of have to go through all of those emotions, and it does feel very normal and, I have felt frustrated and I've felt annoyed. I felt, I just want to get this done, but I just had to stop and just say 'it's okay, it's all right'."

Introspection

This introspective moment was very poignant, hearing a tape again and the profound value of OT providing space and time for child just to be. This led to lots of reading about existential therapies and approaches.

"I have been checking transcript accuracy and put the tape on, want to check out and feeling there's very significant content existentially speaking in OT's allowing people just to be and to witness them to provide dignity respect and non-judgemental approaches."

(Research Diary August 2015)

Interpretive Phase

From MQ research journal 26/10/15:

“10 Reasons Why You Don’t Know What OT Does”

1. OT's focus of the child having a voice-not being heard themselves
2. OT is with kids, they adapt activities and simplify activities to enable children to achieve/understand mastery-not to promote their own mastery
3. OTs work in environments which best suit the child, not the boardrooms (playrooms not boardrooms)
4. The most important relationship for the OT is the trusting one with the child, not the Commissioner
5. OT's power stems from uncovering the child's power not their professional power
6. OTs view time is a precious commodity: allowing the child to choose when they step forward into the lime light, not when the OT steps forward.
7. An OT's sense of agency stems from the child discovering their presence in the world, not stamping their own
8. OT is a 3-D embodied intervention-a two-dimensional picture and text misses out the essence which is real human presence and interest in the child
9. OT is an embodied human to human transformation not easily Captured in the electronic care record
10. Until now, no-one has asked OTs what the essence of effective occupational therapy is, so the outcomes they try to use, don't capture what is needed for evidence of real effective help for young people.

A Question: Do OT outcome measures actually measure the important outcomes to CYP & OTs?”

‘Made in occupational therapy’

- Do they notice a flicker of an eyes first eye contact?
- Do they notice a pencil gripped correctly and the glint of a confident smile?
- Do they notice a child stepping into a writing group instead of playing in the sand?
- Do they notice a smile under a torrent of scowls?
- Do they notice a vortex in a child's troubled mind?
- Do they notice the shadow of a moustache on a boy, turned man, who unpacked his ‘handmade in OT’ Christmas tree decorations, for the first time last year?”

Ethical Tensions and Resolutions

	Ethical Tension Encountered	Resolution
Pre-research Phase	<ul style="list-style-type: none"> • Managerial position and bias towards the use of outcome measures for the marketing of OT • NHS and my aligned acceptance around the supremacy of positivistic approaches and erring towards objectifying CYPS OTs as non-compliant in their use of outcome measures. 	<ul style="list-style-type: none"> • Reflected on proposal feedback. Sought academic supervision and mentorship from expert in reflexivity, to challenge motivation and explore alternative research design. • Reflected on a motivation behind the study: to strategically influence on behalf of OT and CYP. Took one year extended period to better understand the ontological underpinning and epistemological stance, which resulted in a more congruent choice of methodology which reflected professional philosophy and spirit of working respectfully and collaboratively with OTs. Responded to the requirements from the Ethics panel to enhance the PIS and the Consent form.

Data Gathering Phase	<ul style="list-style-type: none"> • Participants who attended for interview who had not read the Participant Information Sheet (PIS), which included information on informed consent and withdrawal. • Contrast between the OT and Nursing Approaches to care A theme emerged highlighting the contrast between the approach in occupational therapy sessions (as empowering and child centred) and the behavioural management ward culture. Examples were given of nursing staff needing to manage the challenging behaviour of multiple young people, high levels of observation resulting in a lack of privacy and focus on problems posed for nursing staff, rather than the child's needs. This created an ethical tension borne out of the contrast in philosophical approaches of OT and Nursing. 	<ul style="list-style-type: none"> • Talked through all aspects of PIS, provided time for questions. Read through Consent form and reiterated rights to withdraw. Ensured consent was fully informed and kept signed copies of written consent secure. Provided participants with a Debrief Information Sheet, offered to discuss at time or at any later time. • Discussed issues in academic supervision with supervisors (specialists in nursing and research ethics). The researcher raised clinical practice concerns with service managers. Assurance was given that they were aware of the challenges brought about by high levels of self-injurious and unsafe behaviour on some wards. Managers had active plans to ensure ward cultures prioritised the safety of young people and promoted personalised care and privacy.
Data Analysis Phase	<ul style="list-style-type: none"> • Desire for objectivity related to coding decisions in the light of embodied impacts of material from interviews, personal reactions to hearing the work of OTs, feeling proud of their work. As an insider researcher, hopeful in identifying the value of OT with CYP. 	<ul style="list-style-type: none"> • Monthly discussion in supervision with both supervisors, one of whom specialises in ethics. Maintained an active research journal throughout doctoral process and beyond. Debated and decided on inclusion of a reflexivity chapter to ensure transparency, trustworthiness and accountability.

	<ul style="list-style-type: none"> • Concerns regarding the descriptive data analysis process being too orientated towards identifying the essence of effective OT and at odds with Heideggerian methodology, following attendance at International Quality Methods Conference. 	<ul style="list-style-type: none"> • Identified any areas of concern with supervisors, e.g. PDTA coding, re-aligned project methodologically. Captured personal skill development in research diary and researcher development portfolio. Used research diary and monthly supervision records as a source of data. Coded and analysed reflexivity, appropriate to the research aim and objectives. Reported all aspects of ethical tensions in reflexivity chapter.
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Reflections on the Methodology

Following the International Qualitative Methods Conference in 2016, a reflective account was created which looked at the methodological conflicts of some of the language used in draft chapters (see Appendix 20) around the essence of OT. This led to a refinement of terminology and a reinforcement of the interpretive aspects of phenomenology. It strengthened the philosophical congruence at the heart of the study and developed a greater understanding of how to apply methods within interpretive paradigm. Revising the research aims and objectives enabled the researcher to become increasingly interpretive and develop confidence and skills in the approach taken.

Reflexivity and the Professional Doctorate

It is a requirement of professions regulated within the United Kingdom that they continually professionally develop and the activity of being both reflective and reflexive is core in order to remain a registered professional (Health Care Professions Council, 2012). As this research is being undertaken as part of a professional doctorate, it is important that links are made to ongoing learning (Lee, 2009), improve clinical practice and contribute to the development of the profession. Consequently, this process of reflexivity is ongoing and will stretch beyond the scope of this thesis. However, recommendations for practice will be included later and suggested practice implementations will be reported through peer-reviewed publications. The College of Occupational Therapists' annual conference in June 2016 provided an opportunity for the sharing of findings from this study with peers. A personal research journal has been used

throughout the course of this doctoral study and will continue to be an important aspect of professional development throughout this professional doctorate, logging areas for future development.

Conclusion

This chapter offered a reflexive account utilising transcribed data from a four-year reflexive diary, supervision records and interviews with participants. Thematic analysis was carried out using NVivo software and presented the selected approach, with pre-determined nodes/codes whose definition was clarified. In the light of the research aim and objectives, it illuminates critical issues, thereby allowing the reader to assess the credibility and openness of the research undertaken. There is a growing body of agreement regarding researcher influence on a study (Probst, 2015, Berger, 2015). Finlay (2002b) posited that the researcher influences the research through their position, perspective and presence. Consequently, the analysis looked at the three phases identified as pre-research, data collection/gathering and data analysis.

Drawing upon Finlay's conceptual map of reflexivity (2002a), each stage of the research process has been discussed using the five categories of reflexivity identified as relevant to qualitative research. The purpose of such an exploration was to allow the reader to critically appraise the trustworthiness (Lee, 2009) of the research undertaken and to provide a transparent (Guillemin and Gillam, 2004, Pillow, 2003) account of the researcher position within the research.

Chapter Nine: Discussion

Introduction

This discussion chapter draws on the findings which have emerged from analysis and seeks to integrate and contextualise them within literature related to occupational therapy with CYP. Firstly, the relevance of the research findings to the current clinical context, within which OT is delivered, will be outlined.

Section two puts forward diagrammatic synthesis of the research processes and an overview of what constitutes congruent occupational therapy practice when it is effective. An enumerated visual presentation of findings, showing integration of all aspects of the multiple modes of analysis, will be offered to guide the reader to deeper levels of understanding through the complex integration of contextualised findings. The principle five findings are: child-centredness; authentic relationship; time and space; grading activities and environments; and goal setting. Each is discussed within the overarching approach offered by the occupational perspective of health (OPH).

Section three looks at occupational being: having a child-centred approach; establishing an authentic relationship; offering time and space within which the CYP can develop their occupational being; and addressing issues of occupational alienation. Section four then discusses: occupational doing and providing time and space; grading activities and environments; and working on goals and minimising occupational imbalance. Section five looks at occupational becoming, grading (environments and activities), setting goals and addressing occupational deprivation. This is followed by an exploration of

occupational belonging: the authentic relationship; goal setting; and uncovering occupational marginalisation.

Section seven presents an interpreted metaphorical explication of effective OT with CYPs and the professional practice impacts of this work. Finally, the main themes of this chapter will be drawn together in a conclusion. These overarching insights will inform the recommendations for future practice and research.

Occupational Therapy Practice Context

The context within which effective occupational therapy is delivered will be outlined in this section, along with a review of its relevance and importance since this research was first conceptualised. Defining effectiveness from the perspective of CQC and occupational therapy's position within this agenda will be discussed. Use of the Occupational Perspective of Health (OPH) and centralising the concept of occupation will be discussed for its overall utility. Emerging issues regarding the implications of this research will be outlined, and then further detailed in the recommendations chapter to follow.

The Importance of Effectiveness

Increasing clinical demands, combined with the increasing financial pressures that are impacting the NHS, render the broad question of effectiveness as relevant now as it was four years ago, when this project was first conceptualised.

Care Quality Commission (CQC) Definition of Effectiveness

The CQC ask the same questions of all services and are core to how they regulate. Specifically, they ask:

“Are they effective? *Effective*: your care, treatment and support achieves good outcomes, helps you to maintain quality of life and is based on the best available evidence.”

(Care Quality Commission, 2016a)

CQC (2016) Key Recommendations: “Not seen, not heard”

A recent CQC publication (2016) recommends the following:

“Children and young people must be actively engaged in their care
Services must ensure their focus is on outcomes
More is done to identify children at risk of harm
Children and young people must have access to the emotional and mental health support they need”

And resonant with the findings of this study, it states:

“Many highly motivated and skilled staff working with children want to make a lasting difference. However, it is often obstacles within the system that prevent progress being made”

(Care Quality Commission, 2016b, p. 4)

Drawing on evidence of recent enquiries, CQC summarise that system failure is often due to the child’s voice not being heard. Summarised in their first finding as:

“The child’s voice: the silence is deafening” citing:

“The United Nations Convention on the Rights of the Child (UNCRC, 1989) protects the right of children and young people to be involved in all decisions that affect their lives”.

(Care Quality Commission, 2016b, p. 9)

Fundamental to effective occupational therapy is the centredness of the voice of the child, the drive to remove obstacles which hamper progress, evidenced in this research, and the reflectiveness of a profession actively seeking to support children's rights.

Occupational Perspective of Health and Occupation

The decision to frame this discussion chapter using the OPH has been carefully considered. Methodologically, findings of an interpretive phenomenological study can have a more artistic style as:

“...creative analysis can be a way of “giving voice” to participants, as well as a way of handling data and presenting research findings about the phenomenon itself.”

(Finlay, 2011, p. 241)

Eloquent quotes and descriptive metaphors have beautifully illustrated how deeply embedded in original material the findings are. As a professional doctoral study, illuminating practice implications, this is a crucial aspect of the research endeavour. One of the key overarching insights gained through this research, arising from the Lifeworld discourse (Ashworth, 2003) analytic element, is how rarely respondents used a language of occupation to articulate the effectiveness of their practice. In a field where surprisingly little has been published, housing the discussion of findings within the lexicon of occupation offers a first step to contribute to bridging the Lifeworld of practicing CYPS OTs with the wider occupational therapy/science academic world. Consequently, the following discussion will be structured using the OPH and the Flower image

(Figure 22) which reflects it, which will help to guide debate and the complexities of interactive elements of this study's findings.

Re-capturing the artistic spirit of this interpretive phenomenological research, this discussion chapter will culminate in a summative, interpreted metaphor of effective occupational therapy, endeavouring to give voice to the occupational therapist and, ultimately, the rights of children.

Summary

Striving to understand what makes occupational therapy effective is as relevant an endeavour now, as it was four years ago when it was first conceptualised as a focus for research. The Care Quality Commission (CQC), which regulates the National Health Service in England, considers practice to be effective when it facilitates improved quality of life and good outcomes. Supported by the Health Care Professional Council which regulates the profession and requires such CQC standards to be met, occupational therapists are therefore tasked to ensure that occupational therapy with children and young people achieves good outcomes for them and contributes to a better quality of life. The use of the OPH has been explained and emerging issues regarding the implications of this research will be outlined and further detailed in the recommendations chapter to follow.

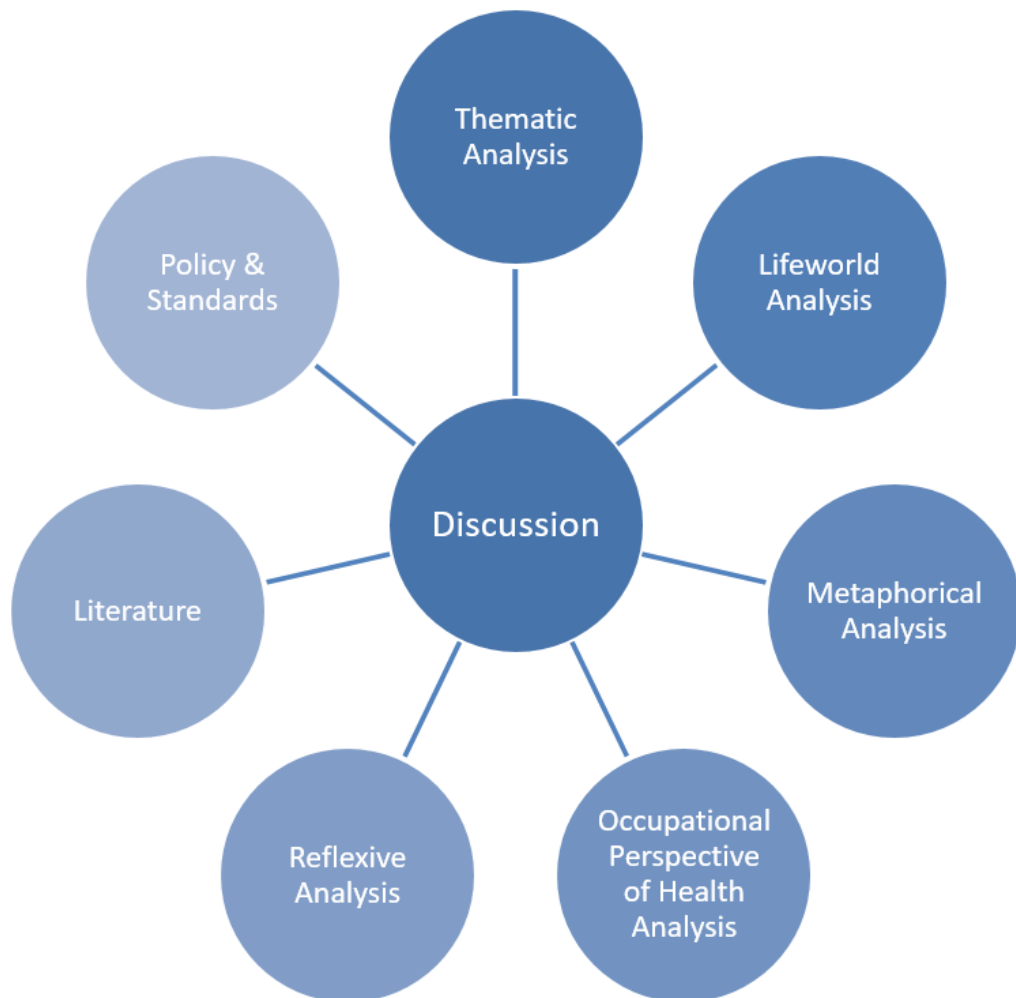
Visual Synthesis of Data Analysis

Multi-layered Analysis

A range of analytical approaches were utilised to fully explore the qualitative data collected, foregrounding different perspectives in the process. The research aim was met through meeting research objectives (one, three, four and five) around themes (thematic analysis), Lifeworld fragments (Lifeworld analysis) (Ashworth, 2003) and the OPH (Wilcock and Hocking, 2015) (Occupational Perspective of Health Analysis), and offering a metaphorical explanation (metaphorical analysis). The intention was to comprehensively explore the phenomenon of effective occupational therapy, and maximise the use of the data set to gain a breadth of understanding as well as rich and nuanced insights.

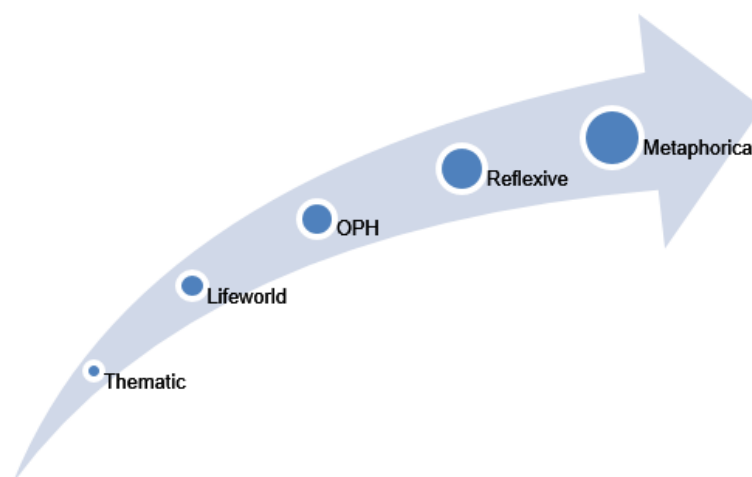
The multi-layered nature of this analysis is visually represented below (see Figure 20) and further discussion will draw upon the insights gained from the various strands of analysis undertaken, within the context of related literature, policy and standards.

Figure 20: Multi-layered Analysis



Finlay (2011) postulated that phenomenology could be viewed on a continuum, with Husserlian descriptive at one end and Heideggerian interpretive approaches at the other. Whilst this research was the latter, the five methods of analysis were increasingly interpretive in nature as the analysis progressed (see Figure 21), and researcher skills and competency developed in line with the methodological framework.

Figure 21: Interpretive Analysis



Hermeneutically (Crowther, 2011) returning to accounts, focussing in, seeing anew and gaining new insights drew the researcher into an ever-deepening and changing understanding, noticing previously seen details from a different perspective. The various angles from which the phenomenon was analysed, and subsequently viewed, providing an ever-changing kaleidoscope of perspectives. These increasingly interpretive phenomenological methods applied to a previously hidden phenomenon provide the opportunity to contemplate it in many different lights, and thus experience the phenomenon on many levels: intellectually, sensorially, emotionally and as an embodied experience. This process can mirror how the lived practice and experience of

effective occupational therapy impacts on the young person and the occupational therapist: they see it, feel it, partially understand it, and intuitively grasp other aspects, as an embodied, involved, visceral experience.

Lived Experience of Effective Occupational Therapy

This study showed a surprising level of coherence in the descriptions offered of: where effective OT happens; what happens in sessions; the professional skills being used; and underlying philosophical approaches. Passionate and heartfelt opinions were put forward as to the most important ingredients of effective occupational therapy. There was no hesitancy in describing, in concrete terms, example after example of effective OT sessions. Such rich data has lent itself to multiple modes of analysis.

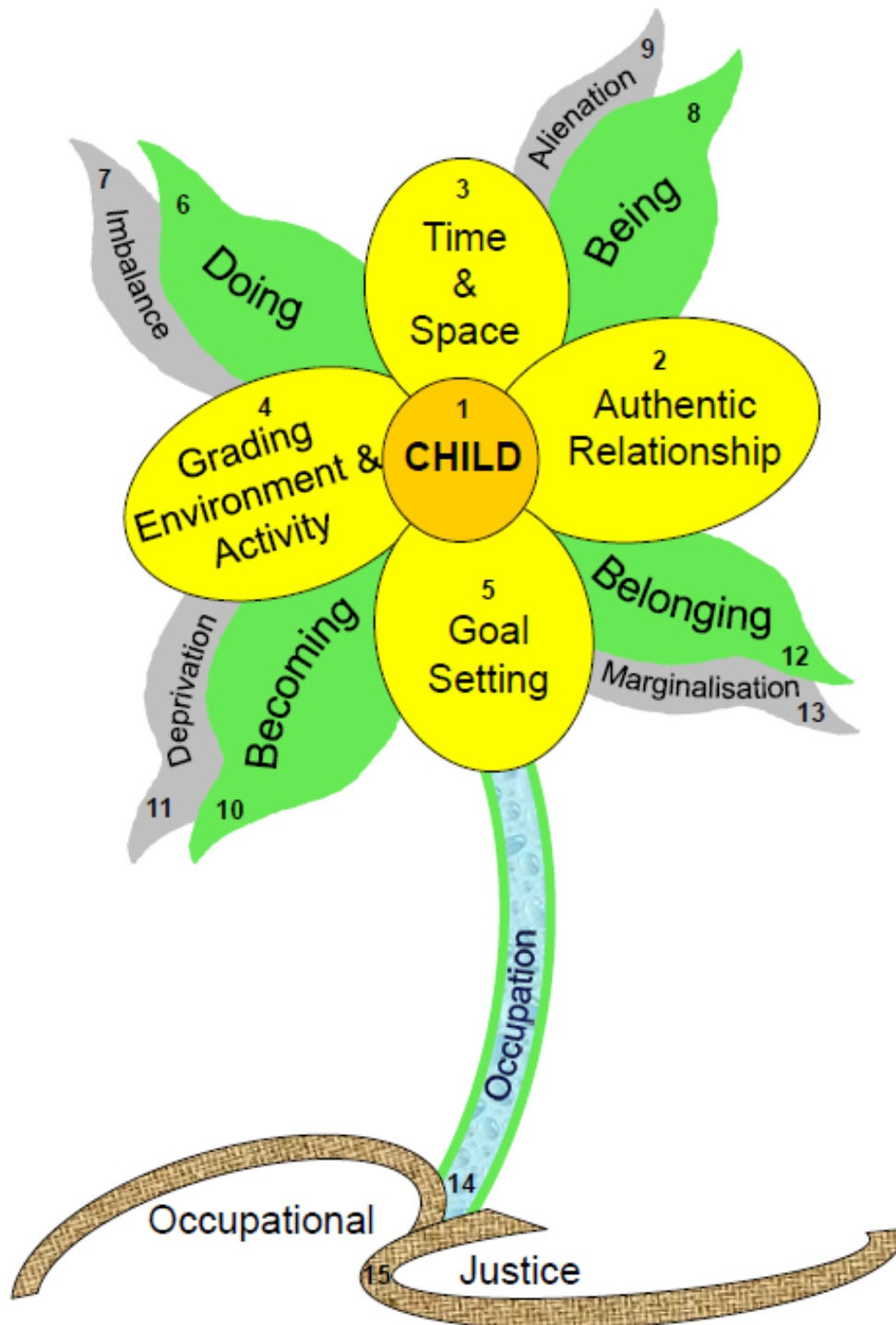
Visual Synthesis: Effective Occupational Therapy with CYPs

Synthesis of the totality of findings resulted in five main themes. These principal areas interrelated with the occupational perspective of health (OPH) concepts of: occupational justice; occupation; doing; being; becoming; and belonging, and their related occupational risks. These fifteen elements (notated thus: 'F1-15') are shown below (Figure 22) in an artistic format, showing a visual synthesis of findings, and will be used to structure this discussion. Inspiration for the image of a flower came from Bernadette's metaphor: her sense of a young girl she was working with, transforming from being like a brown dying leaf to:

“Being like sunshine: it's just...seeing her blossom and grow.”

Figure 22: OT Flower: Effective OT with CYP

Effective Occupational Therapy with CYPS



Effective OT with CYP: Enhancing Occupational Being (Flower 8)

This section uses the synthesised visual representation (Figure 22: OT Flower: Effective Occupational Therapy with CYPs) with reference to its numerical indicator for each element referred to below. Commencing with Occupational Being (Flower: 8 or F8), the findings of the study are used to explore and extend Wilcock's definition of Being and what it means in the practice of CYP effective OT. Pivotal to facilitating being (F8) is child-centred practice (F1), emphasised by all participants, and the creation of an authentic relationship (F2), by providing time and space (F3) in OT. Avoiding the isolation caused by occupational alienation (F9) will be debated, particularly the role of OT in: transitions; upholding professionalism; and providing pre-decision making support to vulnerable children.

Being (F8)

If you have not seen an in-patient CYP MH/LD ward, it is difficult to imagine how distressed and behaviourally disturbed some children can be. Often there is a behavioural manifestation of a problem, which needs to be managed (minimum ratio of 2:1 staff to patient and up to 6:1) to avoid harm to the young person or those around them. This presentation prompts the admission, despite national policy and best practice (Quality Network for Inpatient CAMHS (QNIC) and Quality Network for Community CAMHS (QNCC), 2013) to always endeavour to support the CYP to remain in their familiar home environment. It is the last resort. Wilcock explains Being (F8) as:

“of the mind, inner person, essence, core spirit, personality.
Essential nature of someone; substance.
Mental/spiritual self.
Ideas and plans formed, sense made of how to do
Reflective or restful
Relaxation and sleep phases of occupation

Alternates with action and toil.”

(Wilcock and Hocking, 2015, p. 136)

For young people in Tier 4 services, there may be little planning, concept of their inner person, or notion of their fundamental nature and, by definition, they will still be developing their personality (Berk, 2012). Consequently, Wilcock’s (2015) health-orientated and developmentally advanced definition of being seems a long way from the chaotic presentation which catapults children into these most specialised services in England.

So, what is occupational being within such services and for such children who find themselves there? This research found the notion of being to be not only about thinking, planning and reflection, but also about “seeing the child for who they are” (Bernie), for others and, more importantly, the child themselves.

Whilst Wilcock referred to the philosophical and psychological well-being aspects of existentialism in the wider descriptive context of being, little of that existential element is brought through into the explanation of being or the associated occupations of:

“Time out, reflecting, planning, deciding, organising, relaxing, sleeping, resting”.

(Wilcock and Hocking, 2015, p. 136)

This research points towards the existential aspects of being as the core to effective occupational therapy. Unlike existential therapy (Yalom, 1980), occupational therapy differs in its focus as a doing (F6), and not talking, therapy and, as such, it remains appropriate to utilise the notion of occupational being (F8), advanced by Wilcock. This research seeks to enhance the clinical utility of the OPH model by suggesting that being, within

an occupational domain, and with CYP, has an existential element to it, which would be worthy of further research.

Child-Centeredness (F1)

Effective occupational therapy with CYP reflects the practice application of the WFOT statement: that the essence of occupational therapy is client-centred (World Federation of Occupational Therapists, 2012a). This issue is so central to CYP occupational therapists that it influences all aspects of effective occupational therapy, as captured in the flower image (F1). In practice, occupational therapy is most effective when the child is leading and deciding how they wish to use the session, working towards their identified goals, and the occupational therapist is purposefully grading and adapting the activities and environments to enable (F4) them to meet their goals.

Authentic Relationship (F2)

This research has clearly shown the beliefs and attitudes OTs (see Figure 22) hold regarding the importance of having an authentic relationship with the child based on, inter alia, a respectful, empathic, honest and non-judgemental approach. Resisting objectification of the child, as a set of behaviours to be managed or symptoms to be treated, the OT provides an embodied presence, reaching out to children who may have withdrawn from interaction. CYP are seen in occupational therapy as individuals with potential, unique capacities and resources to be the experts in themselves. Initial steps to build rapport and trust utilise advanced communication skills (e.g. non-verbal communication,

mirroring, matching) to convey the OT's desire to step outside of their familiar style, to align with the young person and respect the child's right and choice to engage or not. When effective, OTs demonstrate a suite of capabilities which resonate with engagement theory (Ziviani, 2015), and set the ground for their therapy to be effective by virtue of the firm foundations set in establishing an authentic relationship from the outset. It is respecting and believing in the child for who they are and is an important step in developing their emerging sense of occupational being.

Time and Space (F3)

Providing the young person with both time and space appears to be core to effective occupational therapy in existential terms. Occupatiotemporality (Zemke and Clark, 1996) and the shaping of how time is experienced are concepts which the CYPs OTs in this study showed an understanding of, in practice. It is resonant of the Csikszentmihalyi (1990) concept of flow and time suspension (Larson, 2004) whilst absorbed in an activity. Whilst Larson identified that there was little evidence that OTs had embraced temporal perspectives, this study shows that it is an important, and previously unreported, aspect of ensuring occupational therapy was effective for the CYP with MH/LD.

Focussing on OT in practice, Pemberton and Cox (2011) recognised the need to facilitate the translation of theoretical models of time and occupation into practice, with a comprehensive overview of how occupations provide meaning to how we live our lives and how it defines our being. The implications of their work will be picked up later, when the doing (F6) aspects of time are debated.

The concept of space, especially when coupled with time, is often a euphemism for freedom and the opportunity to do something, within a given timeframe (Lee, 2007). Interestingly for occupational therapy, time and space are often separate entities, with activities and occupations often occurring in places, or physical spaces, which the CYP may not normally be in or have access to. As such, the choice of spaces or environments offered (kitchen, gym, shops, OT room, playroom), within which OT happens is a carefully considered component of effective OT. The provision of space impacts on the CYP's occupational being, potentially addressing developmental delays which

may be an important stage which enables self-regulation in the future (Roseberry et al., 2009) and requires both time and non-judgemental space within which to be any number of future imagined selves.

Occupational Alienation (F9)

The shadow side of being, or associated occupational injustice, is occupational alienation (F9) (see Figure 22), which occurs when CYP experience a sense of disconnectedness, isolation, lacking identity, meaninglessness and limited self-expression. The role of CYPs OT, in building rapport and decreasing isolation, appears to be a central endeavour and directly related to CYP developing their sense of identity as an occupational being.

In relation to the higher goal of helping CYP to develop their occupational being, OTs described mitigating risks of isolation by bridging transitions. However, this holding function of maintaining stability in times of transition (e.g. change of carer, school) rankles with the philosophy of facilitating independence. Subsequently, the role of OT in addressing issues related to occupational alienation can easily be missed, without a full understanding of the wider conceptual framework which the OPH brings and its associated responsibility of OTs to uphold occupational justice (F15).

An example of effective occupational therapy was provided when intrusive questions from children, were responded to in a professional way by maintaining boundaries (Health Care Professions Council, 2016). The OT interpreted such queries as emanating from the CYP's sense of disconnectedness or isolation (F9). The implication being that MDT who

provided personal information may miss an opportunity to address the child's underlying issue. In the light of the Francis Reports (House of Commons Library, 2013), OTs need to challenge unprofessional behaviour of ward colleagues if they become aware of some interactions with CYP becoming too familiar, or lacking a professional boundary.

The following detailed analysis of an example of occupational alienation (F9) is provided for its powerful illumination of an otherwise hidden phenomenon, which, in practice, may be a significant issue for young people who are weighing up a big decision on their own. It is based on a case described in detail by Diane.

A young person voiced her sense of isolation (F9 occupational alienation) caused by a safeguarding policy based on the Children's Act, which intentionally aims to protect children, but which rendered her unable to talk about the possibility of disclosure of abuse without prompting a full-scale safeguarding intervention, with its associated family fall out.

Making the decision to disclose abuse is an onerous responsibility for a young person, with many such individuals disclosing abuse as adults instead (Dodgson, 1996) for risk of disclosure earlier. In adult mental health, this pre-decision phase is referred to as a contemplative stage (Ng et al., 2012). Interventions are offered to adults who are weighing up the pros and cons of a future decision, where motivational interviewing questions are posited to enable the adult to make the right decision with agency and control, while being fully aware of the implications of the decision made.

Where children are saying that they require such pre-decision support (as reported by Diane) prior to disclosure, should they not be afforded the same rights as older people, under the Equality Act? (UK Government, 2010). Should young people who pass the Gillick (Gillick competence, 2010) competency criteria, not be afforded the same rights as adults, to clinical expertise to guide them through complex decisions? Currently, children will be considering these disclosure issues alone, or by talking to friends confidentially, and may not have access to expert clinical skills, offered through an authentic trusting relationship, to help them make a therapeutically-informed decision.

The unintended consequence of robust child protection legislation is seen in practice to constrain both the child and the therapist, so that, paradoxically, the pre-disclosure decision-making process for the child is undermined, rather than strengthened. This potentially causes causing greater isolation, as described by Diane, and, in this case, an occupational injustice within the OPH.

Advocating and enhancing self-hood and agency, for someone who has had their control taken from them, was described as a core skill of occupational therapists. Challenging this systemically-caused level of isolation (occupational marginalisation (F13)) could address the inability of abused children to have the support of specialist CYP's services to empower them to develop their sense of self through receiving pre-decision support. OT could facilitate discussion and solutions (e.g. the underwriting of litigious risk within a Human Rights framework, following an in-depth clinical risk assessment of ongoing non-disclosure/abuse) to address issues of occupational alienation

(Flower 9) and occupational injustice (F15), which may, in itself, be the cause or contributory factor to the child's mental health problem.

Occupational Existentialism

The term occupational existentialism has been coined as a result of this research, to capture the sense of children coming into their occupational existence during the course of their occupational therapy. It attempts to capture the emergence of a sense of being or of self, which is occupationally-focussed. This notion surfaced from the findings, where the centrality of developing occupational being (F8) may be interpreted as the route by which the child starts to develop a sense of themselves (their self-hood) through the therapeutic relationship and the emergence of an internal locus of control, evidenced through occupational choices. The emerging identity and setting of meaningful goals could be interpreted as the resolution of a nihilistic crisis, where the primary function of OT is to enable meaning making for the child, through occupation.

Further study to explore the validity of the concept of occupational existentialism with other client groups, such as meaning making occupational therapy with clients with head injury or life-limiting conditions who may be experiencing a sense of hopelessness and those engaged in the dark side of occupations, is recommended (Twinley and Addidle, 2012). Many of the children referred to in this research engaged in serious self-injurious behaviours and violence towards other children, family members or staff. Clearly more research is needed to fully explore this concept and its utility in shaping valued occupationally based interventions for people.

It seeks to extend Wilcock's definition of being as an existential phenomenon, escaping from the disconnectedness of occupational alienation (F9) and the exclusion experienced in occupational marginalisation (F13). These speculative ideas are offered here as early thoughts from which to extend the definitions of being (F8) and belonging (F12), such that they more accurately capture the phenomenon for children with significant mental health problems and/or learning disabilities/autism.

Summary

This section used the OT Flower (Figure 22) and its numbers to identify and explain the interconnections between being (F8), child-centredness (F1), establishing an authentic relationship (F2) and providing time and space (3) within which to develop a sense of self as an occupational being. Wilcock's developmentally advanced and health-orientated definition of being seems a long way from the clinical and behavioural presentation of CYP with MH/LD. Crucially though, the emergence of a sense of being or of self, which was occupationally-focussed, appears pivotal to effective occupational therapy, with the term occupational existentialism being created to capture the sense of children coming into existence during the course of their occupational therapy.

Discussion around the contribution OT can make to reduce the isolation caused by occupational alienation (F9) focussed on: transitions; upholding professionalism; and providing pre-decision making support to children contemplating the disclosure of abuse.

Effective OT with CYP: Enhancing Occupational Doing (Flower: 6)

This section uses the OT Flower numbers (see Figure 22) to discuss occupational doing (F6) and how the data has shown that the provision of time and space (F3) for young people to engage in graded environments and activities (F4) enables them to be meaningfully engaged. Effective OT seeks to avoid young people experiencing occupational imbalance (F7) by being un/under/over-occupied. Wilcock explained doing as:

“Mental, physical, social, communal, restful, active, obligatory
Self-chosen, paid or unpaid occupations
Action, participate, make, execute, prepare, organise, undertake,
sort out, fix, look after
Exploits, deeds, accomplishments”
(Wilcock and Hocking, 2015, p. 136)

Doing (F6)

The simplicity of the invitation from the OT to attend regular, hour-long OT sessions belies the enormity of the step required by the child and the potential impact in their life. Children referred to occupational therapy in CYPS often have a range of presenting problems such as autism, learning disabilities, and post-traumatic stress disorder resulting from significantly harmful abuse as a child, with behavioural presentation requiring protection from serious self-harming behaviour such as head banging and swallowing objects.

When describing how children were using their time prior to sessions, OTs talked about how children were often sleeping for prolonged amounts of time, hiding under the duvet or engaged in challenging, self-harming or self-isolating behaviours, such as staying in the bedroom. Whilst these activities may be of value to the child, the judgement of whether they are good or bad prompts

further questions from an occupational perspective. As highlighted by Twinley and Addidle (2012) the dark side of occupation is rarely investigated in occupational therapy and, indeed, the original definitions of doing, defined it as society-enriching activity.

Effective occupational therapy is a wholly-embodied child centred intervention and seeks to see beyond their presenting behaviour to celebrate their uniqueness. One boy, who needed “an entourage of nursing staff”, when seen by an OT who was confident to be able to manage his potential violence and aggression, was able to challenge his self-concept or being (F8) as an unmanageable monster. He flourished through occupational doing (F6) (engaging in cooking, regressive play and gardening) and, instead of destroying and pretending, learnt to be a different person: making meals, nurturing flowers, sharing fears of becoming a violent man.

Time & Space (F3)

Time and space within the context of doing (F6), relates to actual OT sessions and how time is used as a vehicle to communicate important key messages to the child. For instance, OTs will describe the sessions as “this is your time”, to convey child-centeredness (F1), control and opportunity. Rules regarding safety were explicitly stated by the OT to protect the child, the OT and the equipment/environment, coupled with explanations as to the boundaries of confidentiality, in relation to Child Protection legislation (safeguarding policy based on the Children’s Act), and required organisational practices. Apart from

these absolutes, the young person is invited to use the time and space in whatever way they wish.

Consider an invitation from the OT to the child in relation to time and space (F3): to enter an environment which provides an opportunity for them *to do* whatever they wish to, the doorway to a therapy which has at its heart the belief in an occupational perspective of health. Through *doing* (F6) activities/occupations (F14) the CYP will access a route towards a healthier life (World Health Organisation, 2001). Having established the necessity for it to be the child's choice through a child-centred approach (F1) and offered through an authentic relationship (F2) where the child is accepted for whom they are, this offer of time and space (F3) is the practical, physical threshold they are invited to cross in order to access an alternative route to health through occupation (F14), not offered by traditional, medicalised approaches.

In the wider context, it is important for OTs to consider who has control over decisions about time use (Pemberton and Cox, 2011) and for assessment to include preferred or previous use of time and activities. CYP on in-patient units have little time control. Timetable of activities, lessons provided by education, therapy sessions with MDT and protected meal and bed times are largely determined by the norms of the ward environment. Of concern to one OT participant was how much was expected of children on the unit and her preference to balance such work-like demands with a fun element, as would be had under normal circumstances (occupational balance).

Pemberton and Cox (2014) offer a model of synchronisation between time and occupation, seeing occupational engagement as being in harmony when there

is occupational rhythm, balance and presence in relation to doing. Extending Wilcock's (1998) notion of occupation (F14) as a natural user of time, Pemberton and Cox (2014) postulate that time is also a context for occupation. The findings of this study fit into the synchronisation model, with CYP OT describing effective OT when there is consideration of different children's occupational rhythm (or inner metronome).

Grading Environments & Activities (F4)

The notion of activity analysis is historically embedded in occupational therapy practice (Forsyth et al., 2005) as a way of adjusting an activity or occupation so that it enables the achievement of a therapeutic aim. There are different ways of undertaking such an analysis depending on the OT model used, such as the Model of Human Occupation or the Canadian Occupational Performance Model (Fuller, 2011). Such technical issues were not mentioned as part of this research and investigating the use of specific OT models was outside the remit of the study. However, what was described in the lived experience of OTs was the notion of grading which, although based upon the outcomes of an activity analysis, was independently spoken about in very concrete terms of what was actually going on before or during OT sessions. Thematic analysis of OTs lived experience, showed that they go to great pains to maximise the success of the planned activity. Such was the minutiae of detail, that the code 'micro-grading' was coined in an attempt to capture the nuances of grading happening. Examples included changing moment-by-moment to the child's movements, and honed non-verbal communication and responses to maintain rapport and the child's motivation to remain engaged in

an activity. Strategies included: offering choices of seating proximity; placement of a sheet of paper; adjusting the angle of the OT's chair to the child's chair; counting down seconds to change the environment; choosing environmental space based on the child's presentation within the minutes prior to OT session beginning; and adjusting tasks in response to physical signs of fatigue or disengagement of the young person. Fundamentally, OTs appeared to be micro-grading (F4) in order to facilitate an increased self-belief/self-hood and support an increasingly internalised concept of choice and control.

Occupational Imbalance (F7)

Four distinct areas of OT involvement were identified to address occupational imbalance evident in CYP being un/under or over-occupied, or their occupational lack of meaning. Effective OT seeks to improve environmental access to occupations (F14), such as taking CYP out to the community to shop or have lunch, and advocating for others to enable such activity. OTs support CYP to improve their time-management skills, to improve responsibility for time use and plan activities that are meaningful.

Positive risk taking

OTs can valuably help counter cultural ward/organisationally-orientated risk averse practices, by providing a positive risk taking approach for rehabilitation/recovery, explicating their individual and granular risk assessment. Improving access to restricted meaningful activities through direct provision or negotiation with the gatekeepers of such activities (parents,

ward, OT) can considerably improve the occupational satisfaction of CYP and enable their doing, towards increased participation and health.

Countering the ward norm may also account for the only example given of providing a reassuring touch to a distressed young boy. In an environment where significant numbers of children may have experienced abuse, maintaining professional boundaries are heightened. However, there was very little narrative about warmth and touch when required therapeutically. In a climate where most contact between children and nursing staff was described in terms of managing violence and aggression, it raises the question of the balance between contact in relation to aggression and providing warmth and reassurance: a natural need for developing young people who may be in a hospital environment for months or even years, long distances from family and friends. This query was outside the remit of the study, but worthy of note for professional awareness and follow-up for potential future research.

Summary

Discussion focussed on doing (F6) and how the provision of time and space (F3) for young people to engage in graded environments and activities (F4) enables them to be meaningfully engaged. Four distinct areas of OT involvement were identified to avoid the isolation caused by occupational imbalance (F7): improving environmental access to occupations (F14); improving time management and bridging transitions; improving access to restricted activities; and positive risk taking for rehabilitation. A broader issue

relating to the use of reassuring touch was highlighted as requiring further investigation.

Effective OT with CYP: Enhancing Occupational Becoming (F10)

Integrating the research findings in relation to Occupational Becoming (F10), this section looks at how expert goal setting (F5) and the provision of graded environments and activities (F4) enables CYP to realise their hopes and aspirations. Effective OT (see Figure 22) identified issues and solutions to address the sense of having a lack of control caused by occupational deprivation (F11).

Becoming (F10)

Wilcock explained Becoming as:

“Development
Transformation
Become more knowledgeable or mature
Realize aspirations
Achieve potential
Creation of communal or self image
Foundations for organization of lives”.

(Wilcock and Hocking, 2015, p. 137)

From a sound base of occupational being (F8), an important element reported in effective occupational therapy in relation to becoming (F.10) is goal setting (F5) (Creek, 2003). Respondents described an approach of: being flexible to CYP needs; being adaptable in the moment; and calibrating motivation, assessment of skills and execution of an activity/occupation (F14). It also includes considering occupational balance, including the fun element, which can get lost in the service focus of resolving the immediate presenting problems and their cause. It requires that the CYP assumes responsibility (F1)

and works towards their re/habilitation. Core to occupational becoming (F10) and effective goal setting (F5) is the grading of the environment and the activity (F4). Addressing issues encountered of occupational deprivation (F11) is also an important aspect of effective OT in relation to enabling CYP's becoming (F10).

Grading (F4)

In relation to becoming (F10), the micro-grading of environments and activities offers CYP the relief of not having to work so hard to get the same outcomes/goals (F5), allowing young people to live more, progress more swiftly and have fun.

Goal Setting (F5)

Goal setting with CYP reflects the core belief of OTs, expressed in this research, to facilitate CYP to set meaningful goals for themselves.

The findings of this MH/LD CYPs OT research overlap and are resonant with paediatric OT literature related to SCOPE-IT and SDT (Poulsen and Ziviani, 2004b, Ziviani, 2015). The SCOPE-IT model (outlined in chapter two), appears to capture many facets which respondents in this CYP MH/LD OT research talked about. In particular the need to build a relationship and be aware of past trauma, being predictable and reliable, creating an environment which is safe, being non-judgemental, encouraging autonomy and self-hood, sociality and relatedness and skills acquisition or competency.

Occupational Deprivation (F11)

Within issues of occupational deprivation, OTs identify and address gaps in the provision of opportunities for CYP to engage in activities. They encourage positive risk taking following careful risk assessment and seek to increase access to activities.

Internal Vs External Locus of Control

Effective occupational therapy facilitates individualised goal setting and the development of an internal locus of control (Deci and Ryan, 2000) which may contrast to systemic dynamics which lean towards behavioural management approaches and an external locus of control. Discussion related to the SCOPE-IT model and skills development for CYPS OTs will be further built upon in the recommendations chapter. Most poignant was the direction given to one young man in looked-after services: “You can and must direct your own treatment plans and care” (Cath). This conveys a sense of empowering children to be resilient and robust in a system which was previously described as disempowering.

Time & Commissioned Services

The challenge now is that having identified the crucial factor of needing to adapt to the child’s tempo, or pace of being in therapy, services continue to be commissioned using time-defined packages of care as the currency of defining what is done (NHS England, 2013b).

If what has to be done requires extended amounts of time, then methods of securing atypical commissioning needs for particular children need to be considered. Bespoke commissioning does occur but is usually associated with highly-disruptive behaviour. Paradoxically, the young girl who needed more time to “turn on the lights” demonstrates such challenging behaviours when too many demands are made upon her, so there is a perverse incentive to maintain disruptive behaviour to get additional funding for 3 or 4 additional staff. Even when what is needed therapeutically is more time in occupational therapy, preferably with the same therapist, for her to assimilate her learning at her naturally slower pace and build upon her skills towards independent living. Challenge to occupationally-depriving commissioning approaches could involve use of the Equality Act (2010), which requires ‘reasonable adjustments’ to be made on the grounds of disability where this could involve extended time in therapy for greater assimilation due to learning disability.

In the absence of more time, children are likely to be maintained in a system whose commissioning priorities are orientated towards managing behaviour rather than addressing the underlying issues and need for dedicated slow time occupational therapy to render them less dependent on services. Diane referred to the need to be “pouring the money (currently in adult services), into CYP services” in order to “turn the tap off” and stop the graduation of young people into adult services, and her incomprehension of commissioners not doing so. This is an issue of occupational deprivation, where issues outside of the control of the child are impacting on their goals and aspirations.

It is important to recognise the failure of CYPS OTs to supply commissioners with evidence of the effectiveness of OT in resolving underlying issues and

thereby diverting children from adult care, which in itself is contributing to the occupational deprivation (F11). It is beyond the scope of this research to analyse the political decisions behind funding to the NHS and commissioning priorities, though clearly the financial issues facing the NHS are impacting on children's services (House of Commons, 2016). Providing evidence of effectiveness is a professional responsibility which this study seeks to raise awareness of and start to address, within the recommendations chapter. Broadly, it requires further focussed work on generating evidence to support informed choices/decisions for the health economy and the people it serves, as is ethically required of HCPC registrants (Health Care Professions Council, 2016).

Summary

Here, research findings were integrated to bring a depth of understanding and meaning to the term becoming (F10) and how expert goal setting (F5) and the provision of graded environments and activities (F4) enables CYP to realise their hopes and aspirations.

Wilcock's explanation of becoming (F10) resonates with the findings of this study, where CYP were supported to meet their identified personal goals and develop to the best of their potential. Solutions to address issues of lack of control, caused by occupational deprivation (F11), have been provided, prompting actions for future research and OT practice.

Effective OT with CYP: Enhancing Occupational Belonging (F12)

Occupational belonging (F12) and enabling CYP to have a sense of connectedness was reported in this research as an effective aspect of occupational therapy (see Figure 22). The interpretation of the OPH analysis linked the importance of an authentic relationship (F2) and collaborative goal setting (F5) as factors which enable a greater sense of associations with others (F12). Effective OT also seeks to avoid young people experiencing occupational marginalisation (F13) through being excluded from participation.

Belonging (F12)

Wilcock explained belonging as:

“Affiliations to others/places/things
Being a member, constituent, a part of something
Allied, akin, attached to something
Being in the right place, feeling right and fitting in”.

(Wilcock and Hocking, 2015, p. 136)

As well as establishing a therapeutic relationship (F2) between OT and child, another important aspect of effective OT was facilitating CYP to make emotional connections and develop a sense of agency and self-hood. Examples were provided of OT being effective when it enabled CYP to enhance family connections (like sitting down to a meal together) or improve communication between family members by working with parents and children to establish valued roles.

Occupational marginalisation (F13)

Restricted Tempo of OT Sessions and Enabling Participation

It could be argued that the temporality focus and pattern of delivery in OT, providing one-hour sessions, once a week, is a diktat of how and when OT will be available. Given that OT often enables access to areas that are otherwise off-limits, the pattern of OT provision could in itself be occupationally marginalising (F13). In the broader context, most respondents described occupational therapy as being part of a programme of activities, including educational provision, so the level of participatory impact may be mitigated, but is worthy of note.

Young People's Responses to Ward Restrictions

As with all occupational injustice categorisations, the duration of exposure to them is a factor in how much impact they have, inter alia, level of personal resilience and coping strategy in the face of such obstruction. For example, Antionette described one young person who was obstructed by nursing staff when leaving the ward to go out on a pre-planned OT session (in line with her goals). She persisted in challenging a normative rule, which only applied to CYP sectioned under the Mental Health Act (i.e. getting medical permission to leave), which she was not. She also used official feedback (patient reported experience measure (PREM)) on her mistreatment, instead of previous patterns of challenging behaviour, to appropriately express her dissatisfaction and annoyance. Whilst experiencing occupational marginalisation, she showed her resilience and determination to go out, which she eventually did.

Sadly, not all young people feel as empowered. As such, this example was provided as an example of effective OT which had contributed to her progress.

In a ward situation of vulnerable young people who may have limited freedom of movement, the criteria allowing access to environments and activities, whether explicit or covert, can cause friction. Where identified as a systemic issue, such criteria are referred to as blanket restrictions and are a carefully-considered aspect of CQC and Mental Health Act regulatory processes, with QNIC national standards guiding best practice in this field.

WFOT set out a position statement on human rights which endorsed the UN Declaration of Human Rights, in relation to occupation and participation. Within its associated strategies for action it set out challenges for occupational therapists in the areas of:

“accepting professional responsibility to identify and address occupational injustices and limit the impact of such injustices experienced by individuals”.

(World Federation of Occupational Therapists, 2006)

OTs with CYP raised issues related to ward rules (e.g. use of seclusion in the management of violence and aggression) and CYPs own self-isolating behaviours (staying in bed, hiding under the duvet), which precluded them from establishing a social identity through meaningful occupations promoting citizenship, such as getting involved in Duke of Edinburgh Award activities.

Outreach OT into Isolated Environments

One way in which OTs rose to the WFOT challenge was to provide outreach activities into these isolated environments, providing examples of OT in quiet/step down seclusion rooms and in CYP bedroom space. Whilst only a connection between two people, it represented an important step for very isolated children, and for one young man it enabled him to come out of his “woven basket”, temporarily lifting the lid and choosing to engage with another human, asserting his self-hood and agency, utilising communication skills and establishing a trusting relationship with the OT.

Reassuring Touch

Countering a sense of occupational marginalisation (F13) was also shown by Emily, who provided reassuring touch, as previously discussed, where the invisible normative standards may be to avoid such contact for fear of being accused of overstepping a boundary, especially with very vulnerable children who may misinterpret such physical contact. Providing this contact or simply sharing space in an embodied way whilst doing activities may enable children to calibrate appropriate body contact and personal space norms and experience genuine emotional warmth and reassurance in OT, whether conveyed physically or not.

Summary

This section has discussed key issues (see Figure 22) around belonging (F12), showing that the drive to associate with others and enjoy a sense of citizenship

can start with having an authentic relationship (F2) which involves collaboratively working on establishing meaningful goals (F5), leading to a sense of connectedness.

Wilcock explained of belonging as:

“being in the right place, feeling right and fitting in”

(Wilcock and Hocking, 2015, p. 136)

Having explored the concept here, the definition is in stark contrast to the reality of living on a ward, where other children come and go and manifestations of challenging behaviour are likely to create an impression far removed from being part of something that makes you feel right.

Effective OT seeks to avoid young people experiencing such occupational marginalisation (F13) through being excluded from being able to participate as a citizen, a position advocated in the WFOT Statement on Human Rights (2010).

As can be seen in this chapter, the journey into and out of effective occupational therapy has times of great challenge as well as great success.

Rationale for the Metaphorical Synthesis

The fifth objective of this research was to gather metaphors and offer an interpreted metaphorical explication of the phenomenon of effective occupational therapy with children experiencing mental health problems or learning disabilities. The following synthesis draws upon the metaphors and descriptions provided by participants to capture the phenomenon in a summative artistic interpretation. It was inspired by Diane who spoke of effective occupational therapy as a rollercoaster, with highs and lows. It drew upon the embodied descriptions of Emily and the co-productive weaving of Chris. It seeks to encapsulate Antoinette's togetherness with young people, trying to work around a system, which is not designed for them. It pulls on Bernadette's engrained respect for young people and Cath's tenacity in working for over eight years to provide stability in times of transition.

Fundamentally it seeks to capture the lived experience of OTs and encourage the reader to step into this world and travel alongside the OT and the young person to glimpse its meaning. It seeks to create an embodied experience, visceral, sensorial and emotional. It celebrates and honours both the child and the OT in their endeavours to live more occupationally fulfilling lives. This artistic summary provides yet another perspective from which the reader can view effective OT. Finally, it is my voice: clear, resonant and impassioned, shouting the value of effective occupational therapy, so that more children will be expertly enabled to step away from nihilistic, self-destructive non-existence, into an enriching occupational existence where they are the expert in their own life.

Metaphorical synthesis

The Rollercoaster Ride

I'm queueing, waiting for the next ride.

I'm not afraid. I am courageous.

Oh God-I'm excited, scared, I'm delighted by this journey.

And I'm here-the seat beside me is empty.

I wait and wait and wait for the child to appear.

They're hiding, lost, frightened, alone.

Sometimes it easier to stay under the duvet cocooned in the invisibility cloak.

Sometimes is easier to stay within the shell, like the chick.

Sometimes it's easier to be prickly, like the hedgehog.

I wait-each week I come here and wait-

This is their ride, not mine.

Not this week then, hopefully next week.

Autumn leaves fall-still the seat is empty.

A frosty glare of deepest winter, a heart cold and frozen in.

The green shoots of spring-is there a thaw?

Snowdrops to daffodils-yes, I see them pass the candy floss stall, the sticky
sweet scent of fun.

A hint of pleasure to come.

Where are they going? Not to the ghost train again-to be scared-it's such a
familiar restraint-tied in by fear.

I wait for the next ride. I will never give up on this child.

I wait in stoic hope, determined presence.

I see them.

I see all that they can be.

Capsules of potential, bursting to be set free.

Come on this rollercoaster ride. Don't hide. Be free. Be you.

I notice the angle of the body-they are considering possibilities.

I notice the eyes – darting to seek familiar surroundings.

Diminutive, shrunken, watchful.

I help them on-just the way they like to be helped.

I talk or don't- whatever they prefer

The tentative step,

The hint of somewhere else they'd like To Be.

Yes! They've stepped on board the rollercoaster ride.

And I won't get off until they are ready to.

We are one, close by, two-gather.

I feel the cotton of their T-shirt against my arm.

I notice the rip in their jeans.

Sweaty hands sweep down the denim thighs.

She trusts me, I will keep her safe. I promise.

She can depend on me to bring her to her independence.

We laugh; it's okay to have fun here.

We are in it together now.

The rollercoaster starts

Bit by bit, notch by notch.

Step by slow step. Time frozen.

Minutes are hours, seconds are minutes. It is an endless climb.

This girding, this toning, the muscles ready, the breath deep.

And I am holding my breath-don't put a foot wrong now.

Everything is for her.

She is stepping forward into her own existence, her Being

She is becoming an individual of hopes and dreams

I flex and bend.

I contort my whole Being, to bring forth hers.

And suddenly I realise the rollercoaster has stopped.

The view across the horizon immense.

Our horizons meet and meld.

The wind flicks our hair,

The sun beams from within her.

She has come forth, into the sunlight.

Her face illuminated from within her Being.

The shell is cracked, the chick appears.

The hedgehogs' bristles smooth, in the expanse of possibilities.

Endless Horizons of Hope.

A world of opportunity.

Pure quartz clarity.

Facets of brilliance.

Savouring the sweet moment of Becoming visible.

She sees me and I see her.

She is the child within me; I am the adult in her.

We are one.

We are the warp and weft of a tightly woven basket.

We are the pieces of our global jigsaw.

We are the roots and the highest branches.

She is a leader, I follow - Absolutely sure of her direction.

We are Possibility.

We are Becoming.

We are Living.

Existence - short but sweet, that delicious fleeting moment -gone.

The Roller Coaster, metal, cold, gripping.

Silent sliding.

Dreaded anticipation, the world below.

Stomach. Bile. Gravity. Plummeting Death.

I'm not ready...

We're gonna Die-eeeeee

This hurts, life whipping at our face, body shaken.

Blood burning, blood boiling, heart-breaking. Is this hell?

Oh God! This is Life?

Imprisoned by speed and danger.

I hate this part,

Rushing kids who need time

Rushing before the money runs out

What price for child mental health?

Are they mad?

No escape.

Jolted.

Bolted.

Speeding car on rickety tracks.

Didn't I notice the danger? What have I done?

This girl beside me is scared, pushing frontiers.

Puce with life. I know she can do it.

God keep the bolts tight. Keep us safe.

Make the ride last long enough

It's living or nothing.

It's beyond death-it's a darkness of no light, no life, no hope.

And the Rollercoaster drifts to a slow-mo stop....click, click.

Down and up the bank-freewheeling turning to grind.

Pure grind.

Click-a new skill.

Click-the next challenge.

Climbing, slog, learning, participating.

Click-the reaching out... Connecting.

Oh God! The reaching out-hands off the safety bar. Others.

Hands out, ready to re-grasp.

Stretching for.... Something.

Someone else out there.

Is there anyone else out there? Is she all alone?

She wants to belong-to someone-to something

Can anyone else see what she's doing?

What risks she's taking?

The camera clicks-the photo-Proof!

Passport photo to humanity.

Silence. The wind-we've been here before once-but not here.

She's moved on. We've moved on. Her and me.

New Horizons, new vistas, her village, her town, her county, her country, her world, her universe.

Her Oyster

I look at her-she looks into my soul. She smiles.

One last click. Over the last hurdle.

Hands upppppp!

Silence sweeping to planet Earth.

Screams of delight. A million miles an hour now, life-born anew.

Screech of brakes. Dead stop.

The relief. Howls of laughter. We're Alive!

She's alive ... Living Life...Not just existing

Result! Effective occupational therapy...High Five!

Back where we started. But so different.

Look what she's done. What she's doing.

The birth of an occupational being – visible, tangible, measurable.

Anticipating. Participating.

The visibility of becoming-dreams come true.

The reaching out to others – The joy of belonging.

The end of a lonesome journey.

Start of a connected, driven, occupational being.

Now that's what effective occupational therapy with children is.

We wave-she's off now.

I'm discharged by her.

Wow!

And I return to the queue.

I'm made stronger by her courage.

She taught me so much

She led me to a new place

I'm excited and buoyed up by her sparkle.

I'm scared, but the risks are worth it.

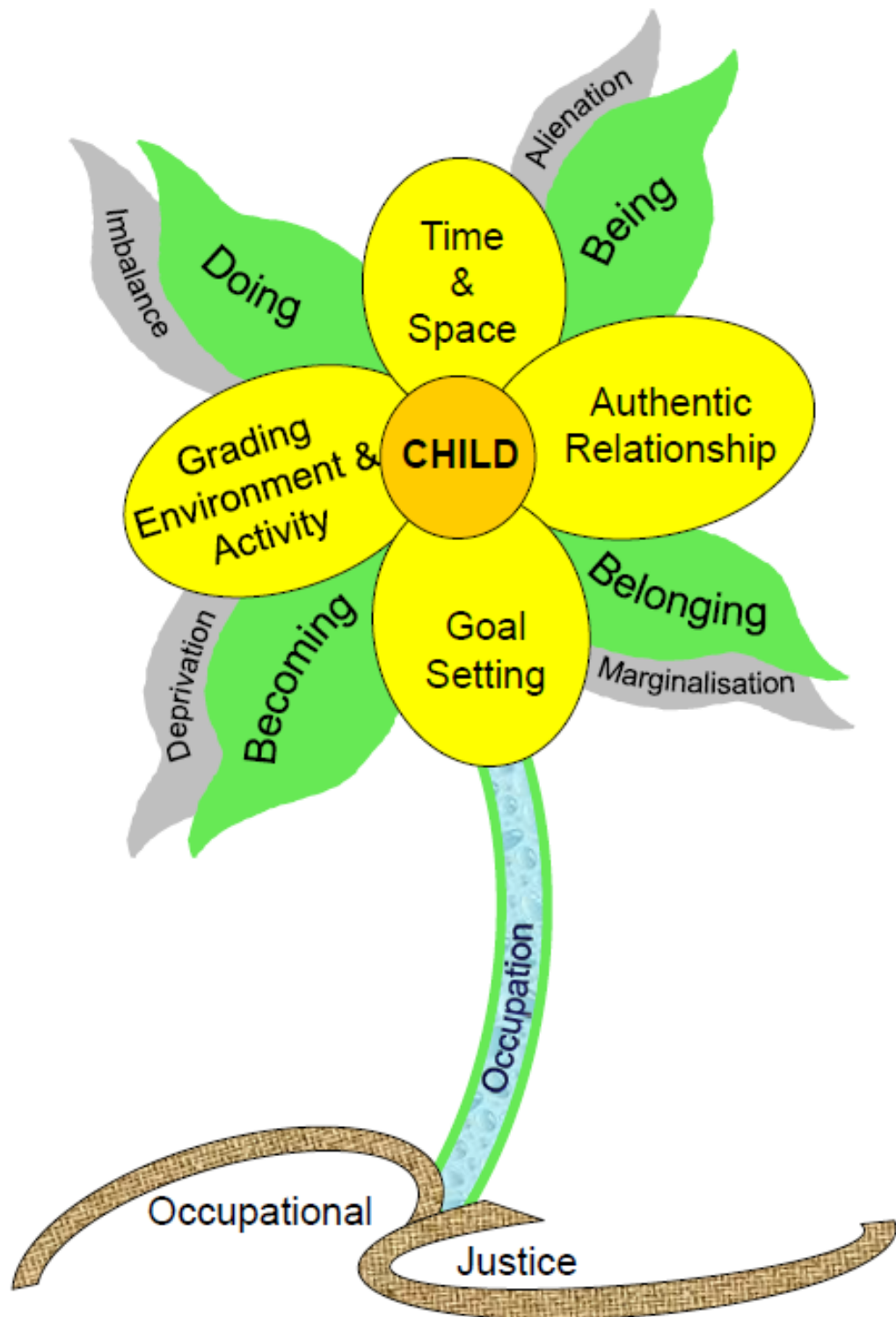
I'm delighted by this journey. I have faith in it.

I'm here-the seat beside me is empty.

I wait and wait and waitfor another child to appear.

By Maria Quinn

Effective Occupational Therapy



Conclusion

This discussion chapter has looked at this research in detail and synthesised its findings into a succinct image representing effective occupational therapy.

The flower image (Figure 22) has been used to explain and discuss the five principle findings: child-centredness; authentic relationship; time and space; grading activities and environments; and goal setting.

These have been individually explored within the challenges of the practice context and the associated occupational domain, and any identified injustice. Implications for practice have been considered in terms of the measurement of outcomes and professional practice impacts captured.

The pivotal notion of child (CYP)-centeredness in effective occupational therapy was illustrated when the child identifies their own goals and leads sessions whilst the occupational therapist grades and adapts activities and the environment to enable young people to meet these goals. The centrality of having an authentic therapeutic relationship with the child was detailed and the importance of the occupational therapists' beliefs, values and attitudes in accepting the child for whom they are was stressed. Underpinning the process of effective OT was that children are given dedicated time and space to enhance their occupational being (Wilcock and Hocking, 2015).

The specialist skills of occupational therapists to analyse activities and occupations, resulting in the micro-grading of environments and activities, means that CYP do not have to work so hard to get the same outcomes and can progress to extend their goals, which encapsulate an occupationally-

balanced and satisfying life. Completing the picture of effective occupational therapy, the task of goal setting was investigated alongside the core belief of OTs to facilitate CYP to set meaningful goals for themselves.

Finally, an interpreted metaphorical explication of effective OT with CYPS was shared. These overarching insights inform the next chapter, which makes recommendations for future practice and further investigation.

Chapter Ten: Recommendations

Introduction

Recommendations are offered in relation to implications for practice and future research, in line with the sixth research objective. Starting with overarching practice considerations, the findings of this research will be considered in the light of their potential to prompt discussion amongst occupational therapists. The broader benefits for OT of using the Occupational Perspective of Health to provide a lexicon to enhance the articulation of the role and impact of occupational therapy will be delineated.

Unlike the discussion chapter, which foregrounded being before doing, in the light of results, recommendations will revert to the established format of discussing the OPH as: doing, being, becoming and belonging. Reflections on the challenges of enhancing participation and whether the International Classification of Functioning (World Health Organisation, 2001) can help CYPs OTs to support CYP to achieve greater levels of health through systematic use of the model will be summarised.

Outcomes as a result of this research for children and occupational therapists will be detailed, alongside support for the TICD model of determinants of practice (Flottorp et al., 2013), which have had clinical validity and a direct impact upon this research study, at the beginning and end.

Responding to CQC's call for evaluation of services in terms of improving quality of life and outcomes, a toolbox of outcome-related questions will be put forward to facilitate OTs to meet their statutory obligations to appraise their

work for its effectiveness. Offering an embryonic reference point of best available evidence, the intention of this toolbox is to enable OTs to select those aspects most pertinent to their field of work.

Recognising the importance of young people's and therapists' views of OT experience and its outcomes, the tool kit will focus separately on these two parties identified within the phenomenon of effective OT. The aspiration being that it contributes to baseline assessment of current practice, from which future practice and research (which aims to more effectively enable young people to become healthier through the enhancement of their occupational being), can develop.

A focus on enhancing knowledge and learning will look at knowledge transfer issues, areas of specific learning for OTs in practice and links across paediatric care and adult mental health care. Implications for further research will look at challenges of hearing the voice of the child, outcomes, clinical skills in relation to intrinsic motivation, and the use of ICF following this study.

Returning to the heart of the original motivation, recommendations related to influencing decision makers locally, within the MDT and broadly to commissioners, policy makers and the international OT community working the CYP with MH/LD will be made. Finally, current and future research activity will be put forward along with recommendations for future investment in CYP's research.

Overarching Implications for CYP's Occupational Therapy

There are numerous implications for occupational therapy practice arising from this research, in particular the requirement to ensure that therapy is effective. It has become evident that the OPH provides a valuable framework to understand what the role of OT is with CYP experiencing MH/LD. The broader implications of the OPH potential is to assist OTs to better articulate their offering, to aid understanding and communicate its value. This section will recommend OTs to consider its utility and the focus on occupation and occupational justice. Finally, broader quality issues around supervision will be put forward for consideration.

Offering More Effective Occupational Therapy to CYP

Since 2006, and reinforced in 2012, the Health Care Professions Council (2012) have required occupational therapist registrants to consider the effectiveness of the therapy they offer. Despite this, there is a gap in the body of professional knowledge of how this is done and the difference it has made to CYP and their families in the intervening decade. There is now a confluence of statutory and professional requirements, which make it absolutely essential for OTs to attend to the notion of effectiveness within their practice. Why would CYPs OTs not share that learning amongst themselves and, more congruently to their expressed belief and values, with their clients, who they purport to place at the centre (Parker, 2012) of their endeavours? In this study, occupational therapists described examples of effective occupational therapy which, following multi-faceted analysis, highlighted five significant areas: child-centredness; having an authentic relationship; providing time and space for

the young person; grading the activity; and environment and goal setting. These areas could valuably provide a starting point from which OTs in CYPS evaluate the effectiveness of what they are doing. Methodologically, as an interpretive phenomenological study which embraces the philosophical position that there is no singular truth out there, this study enables an understanding of the experience as it is lived and interpreted, as an incomplete but valuable insight and one of a multiplicity of meanings. Thus, occupational therapists may wish to consider whether these categories resonate with their practice. By providing a comparative touch point, an ever richer and evolving tapestry of what constitutes effective OT will emerge.

Offering an Alternative View: The Occupational Perspective of Health

The Occupational Perspective of Health provides a valuable mechanism by which to conceptualise and articulate effective OT with CYP. Within systems which principally offer a medicalised or behavioural perspective of CYP problems, an occupational perspective of health brings a different perspective and points towards re-establishing health through meaningful roles and occupations.

Having highlighted a particular issue in relation to how being (F8) is defined by Wilcock, namely its focus on wellbeing and adulthood, this study adds an emerging notion of occupational existentialism. This surfaced from the findings, where the centrality of developing occupational being (F8) may be interpreted as the route by which the child starts to develop a sense of themselves (their self-hood) through the therapeutic relationship and the

emergence of an internal locus of control, evidenced through occupational choices. The emerging identity and setting of meaningful goals could be interpreted as the resolution of a nihilistic crisis, where the primary function of OT is to enable meaning making for CYP. These are speculative ideas regarding a proffered notion of occupational existentialism, which is worthy of further enquiry. OTs in other clinical areas e.g. paraplegics or end of life pathways, have researched the role of OT in meaning making. This could provide a useful starting point, especially where there is an intent on self-destruction or harm and OT has provided an alternative route to a more meaningful life.

Whilst the OPH concepts of doing (F6) and becoming (F10) appear directly relevant in to this client group, belonging (F12) may also require further consideration. Perhaps because in-patient environments were described as very challenging places, Wilcock's definition inferring a sense of feeling comfortable seems a long way away for the CYP in this study, though not all were inpatients. Nevertheless, this finding does carry some resonance with other in-patient stays – how many people ever describe it as feeling right and fitting in? Perhaps the health perspective encapsulated in the explanations of both being (F8) and belonging (F12) are so far from illness that it warrants further discussion. With in-patient stays being costly, there is a drive not to foster dependency and perhaps the OT in in-patient settings needs to consider the concept of belonging (F12) simply within the previous or next familial context for the child. Nevertheless, many children have disrupted family lives and even their home environment may not feel like a place where they fit in. Conceivably the ongoing state of not fitting in or occupational marginalisation

(F13) could be the primary cause of the CYP MH/LD. Possibly the principle OT contribution to formulation is to provide an OPH analysis or assessment of the duration of exposure to any of the four occupational injustices (F7, F9, F11, F13). What, then, would such an assessment comprise of? Wilcock's view of belonging (F12) involving affiliation to others, places and things, is reminiscent of the previous discussion around occupational existentialism. Perhaps both being (F8) and belonging (F12) are the occupational routes for CYPs to enter into their occupational being as an existential phenomenon, escaping from the disconnectedness of occupational alienation (F9) and the exclusion experienced in occupational marginalisation (F13), respectively. These speculative ideas are offered here as early thoughts from which to extend the definitions of being (F8) and belonging (F12), such that they more accurately capture the phenomenon for CYP with MH/LD.

Occupational justice (F15) appears to offer OTs an opportunity to raise concerns as a legitimate part of the role, as endorsed by WFOT, which may otherwise be considered to be beyond the scope of practice. By acknowledging the roots of social justice, the OPH appears to offer a re-awakening of the founders of the profession to address injustice and promote equality (Meyer, 1977). Overcoming system obstacles (metaphorically described as "jumping hurdles" and "ducking and diving"), was an identified element of effective OT, one which has since been reinforced by CQC guidelines (Care Quality Commission, 2016b) advocating professionals to challenge a system which does not hear the voice of the child.

This element of using the OPH framework was also evident in the discussions around supporting pre-decision making support for CYP contemplating the

disclosure of abuse. Providing equality of therapeutic opportunity, as afforded to adults, where young people are Gillick competent, could address current and potentially longstanding issues of occupational marginalisation (F13) and alienation (F9).

Once again, the Equality Act (2010) may provide a route by which occupational therapists can address issues of occupational deprivation experienced by young adults. Activating their right to have reasonable adjustments made as a result of slow cognitive processing associated with MH/LD issues may result in having longer in occupational therapy, which would better support independent living. This may be especially important at points of transition and where commissioning is pressurising providers to accelerate rehabilitation due to funding implications.

Interestingly, the issues related to providing warmth and touch for reassurance were flagged by occupational therapists in the study, resulting in a practice guidance note detailing the parameters for the provision of such touch and seeking consent and agreement from the CYP.

During the course of this research it has become evident that addressing occupational injustices may require OTs to be more socially political in striving for occupational justice. There is little written about the downside of assuming such a position, not least the conflicting position it could create with decision makers, the very people OTs are intending to influence by means of outcome data and reason. This is beyond the scope of this project, but worthy of note for future debate.

Articulating an Occupational Perspective – Sharing the Lexicon

It was beyond the parameters of this study to investigate where findings sat within established occupation-focussed models used in occupational therapy practice, such as the Model of Human Occupation (Kielhofner and Forsyth, 1997), and the Canadian Occupational Performance Measure (Fuller, 2011). Clearly the interface of the findings of this study with the OT models used in practice will be an important aspect of the reflections made by OT and worthy of reporting on. Further research could assist in looking at how the OPH fits with the current range of OT models used with CYPs.

Use of an occupationally-focussed vocabulary, such as that offered by the OPH in terms of doing, being, becoming and belonging, may have value in articulating, reporting and researching the role of OT. However, such ideas have been suggested previously especially in relation to MOHO and one participant specifically said such moves, instead of assisting understanding, make the reading and reporting of OT assessment and intervention even more obscure to non-OTs. She advocated the use of plain English to describe what is done as best practice and more developmentally appropriate when working with children, especially where they may have learning disabilities. As identified in the reflexive chapter, the focus of OTs is principally on the young people, rather than trying to impress colleagues or decision makers, so the motivation to invest in a complicating language may be seen as contrary to the zeitgeist.

Focus on Occupation and Participation

Use of the WHO ICF has received varying levels of traction across the international occupational therapy community (Farrell et al., 2007). Paediatric occupational therapy has made good progress in influencing and developing the underlying criteria for some conditions such as Developmental Coordination Disorder (DCD) (Poulsen et al., 2007, Poulsen and Ziviani, 2004a) and considering its use in practice and research. Such insights could valuably be investigated in relation to CYPS OTs. The online ICF tools provide a mechanism of assessing and using predefined categories to identify problems in participation and may assist others to understand the goal of OT is to improve levels of participation in life through occupation.

Challenging the Universality of Occupational Therapy Models and Outcome Measures

There is an emerging realisation from occupational scientists and therapists in the international community that some models and frameworks which have appeared to have universally acceptable constructs are in fact deeply embedded in Western culture, with roots in colonialism and other dominating historical narratives (Frank, 2012). Such perspectives urge local occupational therapists to be courageous and speak out for their applied versions OT models and ways of working which reflect local culture and needs and challenge the norm of reporting and fitting into widely held OT models and theoretical constructs. This research showed that OTs found standardised assessments to be largely inaccurate with their clientele, with timed activities underscoring actual ability due to levels of anxiety and slower cognitive

functioning, which belies actual functioning. Generally, OTs described standardised outcome measures as not capturing the picture of the whole child. In the absence of previous research on what constitutes effective occupational therapy with CYPS MH/LD, it is not surprising that available standardised outcome measures are falling short of capturing the salient aspects. Indeed, the original motivation for this research lay in understanding what constituted effective occupational therapy, in an effort to attempt to then capture or measure it, which in turn may lead to more effective occupational therapy provision.

Philosophical Tensions: Stability vs Imbalance

Occupational therapy carries the tension between maintaining a sense of stability for the child to discover their occupational being against the professional anathema of creating dependency. Balancing these dynamics is especially important where children have had highly disrupted lives and the OT role may be to maintain and provide emotional stability through addressing occupational injustice needs for occupational balance, especially in times of transition. There appears to be a valid role for OT in creating a sense of identity and connectedness in response to the child's isolation and occupational alienation. Internalised professional conflict or discomfort surfaces for OTs where their role in addressing occupational injustice issues is not well understood or articulated. Compounding this dilemma may be some theoretical confusion regarding psychodynamic ways of thinking and working, which was articulated with widely varying levels of understanding. A polarity management analysis (Johnson, 1993) of this issue will be undertaken,

presented as part of the practice implication outputs of this study, and used to facilitate a wider debate of such issues to increase awareness and clinical reasoning around how these drivers towards stability appear at odds with the core philosophy of facilitating independence. The broader implication here is to be able to recognise and articulate the role in addressing occupational injustices as one that is valid for OTs and enshrined in the World Federation of Occupational Therapists (2006) Declaration of Human Rights .

Supervision and Support

In the light of the importance of establishing a meaningful, professional relationship and the reality of the highly-disrupted lives many of the children have, ensuring a high level of insight, reflexivity and self-awareness is crucial to effective occupational therapy. In understanding the psychodynamic transference, counter-transference, projection and other dynamics, it is important to put in place necessary safeguards, such as enhanced supervisory support, in order to maintain the optimal balance of stability and facilitating independent living skills, and encouraging the CYPs' internalised loci of control and emerging self-identity. Supervision could consider the practice of occupational therapy as congruent with the expressed beliefs and values of the OT and the notion of containment, as described metaphorically by Diane.

Summary

The broader implications of this study on CYPS OT practice have been detailed and recommendations made for the adoption of the OPH as a valuable

framework in which to conceptualise and better understand the phenomenon of effective occupational therapy with CYP. Reflecting on lessons from international paediatric OT research regarding the value of using the ICF, should be explored for its utility for children experiencing MH/LD difficulties. The principle overarching recommendation is for occupational therapists to meet their statutory and professional responsibilities: to ensure that the occupational therapy they offer is effective in terms of quality of life and meaningful outcomes for young people. Ethically, informed consent is enhanced by enabling CYPF to understand what constitutes effective OT and provide information whereby therapeutic choices can be considered. Articulating the added value of the contribution of occupational therapy should include the overarching perspective that healthier lives arise from enhancing occupational doing, being, becoming and belonging.

Clinical Practice Impacts

Clinical Practice Activity to Date:

Kids Rap

There was always an intention to share the findings of this study with the CYP involved in OT. Consequently, the metaphorical synthesis has since been edited by a song writer (Appendix 21) into a rap version, 'Life's Rollercoaster Ride', for young people within the services where the research took place, to enjoy and use. Supported by occupational therapists, music and art therapists, the CYP will be able to choose if they wish to use it and, if so, how they want to perform it and whether they decide to have an audience. Thus providing an opportunity for their occupational doing, being, becoming and belonging.

Sharing Research or Building Resilience in CYPS OT?

A local CYPS AHP Conference had been planned for 2015, deferred to Spring 2016, aiming to share the early findings of this study and provide an opportunity for clinicians to share best practice across community and in-patient services. Discussion regarding delays and problems with numbers of attendees highlighted a significant issue for clinicians who were so stretched in providing services that they could not take time out to hear or share good practice. This level of work pressure was also evident in the data collection and analysis phases, as it became evident how demanding the work for OTs was in CYPs. Combined with emerging insights regarding the beliefs and values of "never giving up on children", an occupational risk was identified for OT in CYPs who may not be attending to their own occupational wellbeing.

Consequently, a revised AHP CYPS Conference (predominantly OTs) was run to enhance AHP resilience, and supported by local colleges, occupational health staff, well-being practitioners, musicians, College of Occupational Therapists, Unison, and Chaplaincy and sponsored by cosmetic companies. It provided: mindfulness, laughter therapy workshops, massage, free lunch, desserts/refreshments, drumming workshops, cognitive behavioural therapy, physical health monitoring, gifts, goodie bags, thank you AHP gifts exchange (by all sixty attendees), vouchers for local restaurants and individualised plans for maintaining future well-being identified by all participants. In addition, the provisional findings of this research were shared, and the value of the role of OT and all AHPs in the provision of care to CYP was acknowledged. It is an important aspect of these recommendations that the support and supervision needs of OTs working with CYP are identified, with particular attention paid to this within the Clinician Reported Experience Measure (CREM), discussed below and detailed in Appendices (22-30)

Clearly, the transfer of research into practice is a key endeavour (Pentland et al., 2011), and the importance of the support of local teams and having a systemic shared approach to enhancing clinical knowledge is as important for OTs in CYPS as it is in community mental health teams or any other service configuration of clinicians. Understanding the factors which support and hinder such knowledge transfer is important, as is the identification of clinician-related factors such as levels of confidence, emotional resilience, as known factors which impact on whether research being applied in practice (Flottorp et al., 2013). As a professional doctorate, this study has enabled the identification of practice issues which were impacting on knowledge management and enabled

system support for clinicians to be activated, which in turn enabled research findings to be heard by clinicians who would otherwise have excluded themselves from traditional routes of imparting such information. Notably, these identified determinants of practice (Flottorp et al., 2013), with their associated checklists, were used in the pilot stage of this research, which resulted in a phenomenological approach being taken. In these closing stages, the same determinants have been an effective tool in identifying individual health and professional factors, related to cognitive, emotional and self-efficacy components which, with a targeted intervention of acknowledging the need to enhance resilience in OTs, has led to OTs networking and discussing such research being considered in practice. This would not have happened otherwise.

Future Clinical Practice Impact:

Patient Reported Outcome Measurement and Effective Occupational Therapy

The following two sections will draw upon the research findings and discussion chapter to propose areas which occupational therapists might wish to consider when appraising their service for its effectiveness, or otherwise. It provides Outcome Measurement Toolkits for the four main areas, aiming to enhance occupational doing, being, becoming and belonging. It also endeavours to address the needs and rights of CYP (Office of the United Nations High Commissioner for Human Rights 1989) to be involved in decisions and have a good quality of life ('NHS Outcomes Framework,' 2013) through the reporting of their experiences and outcomes (Patient Reported Outcome Measures (PROMs) and experience measures (PREMs)). It will also raise questions and areas for clinician-reported experience and outcome measures (CROMs/CREMs).

Practical Use of the CYPS Outcome Measurement Toolkit

The toolkit is not seeking to devise universal outcome measures but rather to prompt OTs to consider asking, and then considering the responses to key areas of enquiry. Avoiding over-complicating feedback into standardised outcome measurement is an action taken in the light of the study, which showed such measures as having little traction when applied to CYP with significant MH/LD issues. Consequently, this more informal, flexible approach intends to bridge the gap in having no identifiable means of evaluating occupational therapy, beyond the use of standardised measures which were

not designed to capture effectiveness, as understood through this research. Clearly the wording would need to be altered according to the intellectual and communication capabilities of the CYP and the selection of which questions to ask, out of a range of options offered. Over time, it is suggested that OTs add their own questions, as other areas considered significant to providing effective occupational therapy are identified.

These suggestions are provided in a spirit of providing a baseline from which debate and networking can flow, and providing best available evidence, as required by CQC, from which increasingly effective occupational therapy practice can emerge. HCPC Standards for CPD require all OTs to provide effective occupational therapy and meet the five set standards. This outcome measurement toolbox can be used as submissible evidence that CYPS occupational therapists meet all five of the statutorily required elements.

The scoring criteria and use of symbols is drawn from the researched advice of the Picker Institute (Picker Institute Europe, 2015), who collate feedback on NHS services on behalf of NHS England. Identifying those questions most applicable to the practice area, the OT can adapt and amend questions to the needs and capabilities of their client group. Once these are rated by the CYP, the OT can rank issues and create an action plan of areas needing attention. Prioritised PROMS/PREMS can then be looked at using a range of quality improvement methodologies (NHS England, 2015). These include different routes, such as discussion in service user/carers groups, MDT, supervision, OT peer group, or alone. Fundamentally, regulatory bodies would want an overview of how information of such outcomes is utilised and what has changed as a result to improve the service provided. Notes are included for

OTs (see Appendix 22) to pilot the use of these toolkits in practice and to join a network of OTs in CYPs working on effective occupational therapy.

Enhancing Occupational Doing: Outcome Measurement Toolkit for Young People

Please see appendix 23: Enhancing Occupational Doing: PROMS/PREMS for CYP.

Enhancing Occupational Being: Outcome Measurement Toolkit for Young People

Please see appendix 24: Enhancing Occupational Being: PROMS/PREMS for CYP.

Enhancing Occupational Becoming: Outcome Measurement Toolkit Young People

Please see appendix 25: Enhancing Occupational Becoming: PROMS/PREMS for CYP.

Enhancing Occupational Belonging: Outcome Measurement Toolkit Young People

Please see appendix 26: Enhancing Occupational Belonging: PROMS/PREMS for CYP.

Clinician Reported Outcome Measurement and Effective Occupational Therapy

In addition to the rationale outlined in the previous section, the focus here is on clinician outcome measures. Clinician Reported Outcome Measurement (CROMs) are well-established concepts in NHS England commissioning and monitoring of contracts. Section one highlighted the need for further work to better understand the philosophical tensions around stability (to address occupational injustice issues) and independence. Drawing upon the insights gained from the study of embodiment (Ashworth, 2003), it is evident from this research that OTs report a significant range and level of emotional responses to their work with CYP. Consequentially, this new category of clinician experience outcome measures (CREM) has been added in an attempt to capture such experiences as being potentially useful in providing effective OT.

Many respondents talked about stuckness, frustration, blockages, withdrawn isolation and skewed perceptions of time passing, which they linked with the CYP's own emotional issues. By attempting to capture any such embodied feelings, the role of OT in this very personal relationship can be explored and supported through supervision. As one respondent said it is the cases you want to hand over which you need the most supervision with. Coupled with the dynamic that OTs never ever give up, it is important that such staff are adequately supported to ensure their own well-being, as well as maximising the therapeutic benefit which generally emerges from deeper levels of reflection and understanding. It could also protect against the surprise felt by an OT who had worked with a boy for eight years, when he cried at the thought

of her discharging him. Apparently, the OT and the child can view obvious emotional attachments very differently.

Finally, within embodiment, one respondent spoke of the embodied feeling she experienced when important progress was being made. Examination of such embodied responses may enable a more hidden aspect of effective OT to emerge as an embodied and valid calibration of progress, largely unrecognised as an outcome measure in the ways in which such terms are currently used within the NHS. Such intuitive, embodied responses are well recognised within Eastern philosophies and attuned to, instead of tuned out, as may be happening in this situation.

The following four toolkits (doing, being, becoming and belonging) offer a baseline from which OTs can reflect on their practice, based in the insights gained from this study. They offer reflective questions from which OTs can choose those most applicable to their endeavour of enhancing doing for CYP. They can be scored on a Likert scale of 1-5, and from this ranking an action plan can be established. Prioritised CREMs/CROMs can then be looked at via different routes (the multiple routes of CPD outlined by HCPC providing a comprehensive list of examples). Such as discussion in supervision, debate in an OT peer group, shadowing other OT's practice, research, reflection with multi-disciplinary team or alone, and regarding which to prioritise for their continuing professional development, which HCPC define as involving quality issues for service users and services (Health Care Professions Council, 2012).

The analysis of CROMs/CREMs alongside PROMs/PREMs could provide a valuable opportunity to embed patient/CYPS feedback into the CPD and

training needs of the OT, to develop skills in the provision of child centred services.

Enhancing Occupational Doing: Outcome Measurement Toolkit for Occupational Therapists
Please See Appendix 27: Enhancing Occupational **Doing**: CROMS/CREMS for OT.

Enhancing Occupational Being: Outcome Measurement Toolkit for Occupational Therapists
Please See Appendix 28: Enhancing Occupational **Being**: CROMS/CREMS for OT.

Enhancing Occupational Becoming: Outcome Measurement Toolkit for Occupational Therapists
Please See Appendix 29: Enhancing Occupational **Becoming**: CROMS/CREMS for OT.

Enhancing Occupational Belonging: Outcome Measurement Toolkit for Occupational Therapists
Please See Appendix 30: Enhancing Occupational **Belonging**: CROMS/CREMS for OT

Summary

Alongside progress to date, two Outcome Measurement Toolkits which focus on experience and outcomes have been presented: one for CYP (patient reported outcome measures PROMs and experience measures PREMs); and the other for OTs (clinician reported (CR) outcome measures (CROMS) and experience measures (CREMS)). Each considers the four main areas, aiming to enhance occupational doing, being, becoming and belonging, which subsume activity related to addressing the associated injustices of

occupational imbalance, alienation, deprivation, and marginalisation. Each toolkit is drawn directly from the meanings that emerged from the research relating to effective occupational therapy.

Each are offered as proposed areas which emerged from the research and are offered in a spirit of providing a baseline of best available evidence as required by CQC, from which increasingly effective occupational therapy practice can emerge, in the light of reflection and development.

CYPS Occupational Therapists Clinical Skills

Moving on from the clinical practice impacts, this section looks more specifically at the clinical skills that may further enhance practice, if not already being used to an advanced level of competency. As such, it could provide an outline framework within which CYPS OTs could undertake a training needs analysis. Equally, it may prompt discussion in supervision as to the quality and depth of case discussion. Exploring the place of self-determination theory and the SCOPE-IT model (Ziviani and Rodger, 2006, Ziviani et al., 2014, Ziviani, 2015) along with extending professional links within OT, will be considered in the light of practice development and strategic influencing.

Identifying Micro-Grading Processes: Environment, Activity, Occupation

Whilst the micro-grading of activities has been broadly discussed, it was beyond the scope of this project to analyse it in detail. Fundamental to any grading are the skills required to effectively analyse an environment or activity for the potential it brings to extend the level of participation of a young person. Developments within the field of occupational science (Dickie et al., 2006, Aldrich, 2008) may impact on models used in practice, such as the COPM, if the person, occupation and environment cannot be analysed separately. Whilst the depth of debate is rich and deeply academic in unpicking underpinning philosophical tensions, clinicians are left with the reality of a young person seen within a particular environment whilst doing a particular activity. Traditional methods of undertaking activity analysis utilise these components. However, this study uncovered a level of grading to be, at times, adjusted from second to second, and in ways unlikely to be noticed by an

external observer (microscopic body movements, eye movements, adjustments in the angle of a pen or board or proximity/distance of closest limb to child). Mechanisms to identify, calibrate and record such micro-grading were not being used to capture this aspect of the phenomenon has emerged from this research. Having been acknowledged it now requires further investigation beyond this early first step to understand the complexities of working with CYP, especially where they are very unwell mentally, behaviourally or struggling as a result of neurological impairments or learning disabilities.

In the meantime, OTs are likely to describe what they do in relatively simplistic ways (e.g. a cooking session), and this fails to capture the complexity of assessment and intervention skills being used. Occupational therapists entering the specialist field for the first time may be relying on extended periods of induction, shadowing, or learning through supervision, where such skills may be handed down verbally or by example, extending the time taken to become a fully-capable practitioner. Perhaps what was described by Diane as a 'profession almost beyond articulation', is simply a profession lacking the tools to properly articulate the complexity of what is being done through often seemingly simplistic means.

Self Determination Theory, SCOPE-IT & Paediatric OT Links

In the light of the findings of this study, some consideration should be given to the utility of the SCOPE-IT model (Ziviani, 2015), within MH/LD CYPs OT and its potential for implementation (Pentland et al., 2013) and clinical application. One aspect of the SCOPE-IT model, related to the underpinning model using person, environment and occupation (PEO), is under critique from transactional occupational scientists in particular, so there may be value in

looking at motivational and goal setting aspects of SCOPE-IT and critiquing the PEO model aspects, from a CYPs MH/LD perspective.

It is perplexing as to why such shared learning between sub-specialities of the same profession, has not already happened and raises the question of other areas of development MH/LD OT can valuably look to paediatric OT for. There have been focussed paediatric OT research endeavours and resultant clinical impact in relation to goal setting (F5) and participation. Use of the WHO online ICF tools to assess and identify participatory issues has also progressed paediatric OT provision, a field not mentioned by any respondents in this study. As a result of this study, the ICF Model has been flagged with local CYP OTs and AHP community, with further developmental work required to explore the utility of ICF online tools for CYP with MH/LD.

Addressing the statutory requirement of parity of esteem (see chapter two), there is also a requirement for paediatric OT to see the interface between sub-specialities as a more permeable membrane, as outlined in the 5YFVMH. Many children with physical disabilities have associated mental health issues and vice versa, so there is an ethical challenge to the profession of OT to come together as OTs working with children and share the specialist skills of each, for the benefit of all children: with combined physical, mental health and learning disabilities. To this end and as a consequence of this research, an abstract has been submitted to the College of Occupational Therapists specialist section for Children, Young People and Families, to facilitate a workshop on parity of esteem and OT and to present the findings of this study. A joint publication with Paediatric AHPs (in press) on improving participation outcomes and interventions for children, through co-designing future research,

was a direct result of recognising the potential value to joint academic ventures in the future.

Occupational Forms

The example provided in Chapter 7 of the occupational form of cooking identified that this shorthand label was used to describe a vast range of activity. Raising awareness of clinicians about the concept of occupational forms and the need to analyse occupations, separately to the performance of it, is an important output of this study. Making links with occupational scientists who may be interested in analysing how occupations are used within in-patient CYPS services could provide a valuable academic collaboration which could further the research endeavour across the practice/academic to the benefit of CYP. Where other occupational forms have been studied and reported on, for example the use of cooking as an occupation across cultures, OTs could valuably attend to the depth of analysis and consequential opportunity afforded to maximise the understanding of such activity and its use in practice.

Occupational Therapy in Paediatric, Mental Health & Learning Disability

An abstract has been submitted to Occupational Therapy Show in November 2016 offering to facilitate a workshop entitled:

“Time to Change for Occupational Therapists: Parity of esteem and professional collaboration for children & young people (CYP)”.

From the findings of this research it aims to facilitate occupational therapists' working with children and young people to embrace the parity of esteem

agenda and consider how active and meaningful collaboration across paediatric and mental health/learning disability services could make occupational therapy more effective for CYP.

A Polarity Management (PM®) (Johnson, 1993) analysis of the benefits and downsides of separating the physical and mental health needs of children within the NHS, through separate paediatric and mental health commissioned services, will be shared. The workshop aims to demonstrate the use of this quality improvement methodology, Polarity management and De Bono's six thinking hats (De Bono, 2000), to challenge the profession to consider whether traditional parameters of commissioning occupational therapy for children may now be hampering collaborative solutions to making parity of esteem meaningful for young people. The seminar seeks to provide time to think together and challenge thinking about whether current diagnostically undertaken and reported research, maximises the effectiveness of occupational therapy for children young people. The unifying aim across both OT specialisms is to help young people to achieve their full potential as occupational beings. The shared concerns being for the consequences on health for the CYP if they do not meet their full participatory potential (World Health Organisation, 2001). The desired outcome is to encourage research and practice collaborations across Physical and MH/LD OT, which more accurately reflect the professions' espoused philosophical roots.

Influencing Decision Makers

An important underlying current of this research was the opportunity it might provide to influence future decision making, primarily for those CYP who use occupational therapy as a route out of their difficulties. Either directly, through being better informed of what OT is and how it actively contributes to improved health, or by facilitating CYP to actively engage in therapy and thereafter shape service development as a consequence of feedback and involvement in service improvement.

Indirectly there are many who claim to be acting in the CYP's best interests: family, friends, foster carers, OTs, the MDT, social care, commissioners, service managers, researchers, statutory and non-statutory organisations, national workforce and policy strategists, regulatory and professional bodies, the legislature and worldwide visionaries of improvements needed for CYP (WHO, ICF, European CYP rights, human rights, WFOT). How then, can this research study seek to influence more broadly? PROMS/PREMS related to occupational therapy are offered to assist OTs to improve services in the light of feedback. Occupational therapists working with children and adults are invited to challenge historical boundaries related to diagnosis and age, respectively, through engaging in this research, which will be presented through various professional fora.

The wider multi-disciplinary team, commissioners and managers may valuably be engaged in discussions related to the measurement of outcomes that are meaningful to children and young people and those which occupational therapists can show as providing an effective intervention for young people.

Summary

The specialist skills of occupational therapists working in CYPS to micro-grade the environment and activity are currently hidden from scrutiny. In order to assist novice practitioners and speed the process of acquiring/building such skills, further investigation which aims to illuminate these skills may enable CYP therapy to progress more effectively. Studying and sharing experience of occupational forms, such as cookery, may enable a greater level of insight and scrutiny as to the clinical reasoning behind seemingly simplistic interventions. This, in turn, may assist OTs better articulate the value of the contribution they offer to CYP, and the MDT. The combined value of these recommendations for future practice would contribute by influencing decision makers on the intrinsic value of effective occupational therapy with CYP with MH/LD.

Research Impact

This section will consider research activity thus far; the strengths and weaknesses of the study, future opportunities to share the findings of this study within the professional research community and recommend ways to build on the insights gained from this research.

Limitations of Study

A critique of relativism in the exploration of the phenomenon of effective occupational therapy

Ontologically, this study sought truth through the experience of OTs (Wilding and Whiteford, 2005) and the meanings they ascribed to the phenomenon (Heidegger, 1962) of effective occupational therapy (van Manen et al., 2016). Relativism acknowledges and celebrates that there are multiple truths and that these are subjective (Finlay, 2011). Whilst the rationale for starting with OTs has been clarified, the voice of young people is yet to be heard, and it is important to recognise the weakness of this study in not having both parties contribute. Pragmatics and feasibility made it impossible, though steps have been taken to capture the voice of the child, through participatory action research methodology, in relation to effective OT. Future research focus on learning disability and autism could identify other specific issues, which facilitate or inhibit OT being effective.

It is unclear why more community OTs did not respond to the invitation to participate; perhaps work pressure or less effective communication networks outside of a hospital base. Nevertheless, this study did have a majority of in-patient OTs, though of those, many had worked in community specialist children's services in the past and called upon such examples in describing

effective occupational therapy. Future studies would be strengthened by focussing on either one or the other, as commissioning varies across services and the OT offer may vary accordingly. Community OTs are likely to describe the phenomenon of effective occ. therapy differently, this being equally valid, and providing a broader nuanced understanding of the phenomenon.

The findings therefore are not designed to be generalizable and the truths identified do not exist without the meaning or context (Johnson, 2007). Caveats should be offered in relation to the broad application or use of the findings, without due consideration of whether contextual issues are similar or different. Similarly, the CYPs OT Toolbox needs to be amended and piloted with active review of its applicability and utility.

Within this study data was analysed using three different methods: thematic (including metaphorical), lifeworld (Ashworth and Ashworth, 2003, Ashworth, 2003, Ashworth, 2016) and using the OPH. It can be argued that such coding introduce a level of reductionism, which disrupts or fractures the context and dislocates the original meaning. The Rollercoaster ride is an attempt to reconstitute the spirit of the phenomenon, using the source material and to put centre stage the contextual issues experienced by OTs and children in these services as well as the range of sensorial and emotional experienced described by participants.

A critique of the Interpretivist Epistemological Perspective in the exploration of the phenomenon of effective occupational therapy

This study acknowledged and celebrated the researchers' role in interpreting the information received from the OT participants, in assuming an interpretivist epistemological perspective (Malpas and Zabala, 2010, Ricoeur and Thompson, 1981, Turpin, 2007). The interactive element of such a stance and seeking to co-create knowledge, lends itself to insider research. The researchers use of NVIVO software to organise and make the process of retrieval of data across datasets, lends itself to code data inductively from quotes, and re-group codes, such that there is a level of interpretation on the part of the researcher. Whilst producing findings that are valid and trustworthy and deeply embedded in the source material, it has been argued that such an endeavour is at odds with the fundamental Husserlian tenet of bracketing (Paley, 2005, Paley, 1997, Paley, 1998, Paley, 2014, Paley, 1996, Petrovskaya, 2014). How when using a reflexive relational approach of co-creation in research, can the epoche be maintained? The researcher sought to maintain a stance of 'openness and wonder' (Finlay and Evans, 2009) and utilise clinical communication skills to draw out the meaning which participants ascribed to the examples they provided. Despite concerted efforts to counter the influence of being an insider researcher with positional power, it was evident from responses that some participants were consciously aware and referred to being judged or saying the right things or being concerned about skewing results (concern for the researcher, or having tidy results, rather than the topic being fully illuminated). It is possible that this dynamic influenced the level of preparation prior to participants coming to interview, clearly some had

thought - reflected upon - the topic, however a Heideggerian approach endeavours to capture the pre-interpreted, fundamental description of a phenomenon (McConnell-Henry et al., 2011).

The interpretivist position (Canella et al., 2009, Chase et al., 2005, Denzin and Lincoln, 1994, Lincoln and Guba, 1985) could also lead to potential misinterpretation of ward/MDT approaches, where this was not specifically the area of enquiry and examples given were within the context of responding to the question of what effective OT was, naturally prompting a comparator. The area of enquiry being somewhat insular and could be argued, a protected OT world view, within a broad multi-professional healthcare system. Whilst this study has identified important clinical insights, a deeper and broader exploration of the proffered concept of occupational existentialism is required within the occupational therapy and occupational science community, to further explore and illuminate this notion.

Within the interpretivist stance, the insider researchers own conflicts as a clinical specialist, an AHP strategic leader as well as an academic researcher, brings a confluence of intent, celebrated in the professional doctoral endeavour, but which requires careful and ethical consideration. These dynamics have been an active part of academic supervision with two supervisors, one of whom specialises in ethics.

The researchers use of NVIVO software to organise and make the process of retrieval of data across datasets, lends itself to code data and then categorise codes, such that there is a level of interpretation on the part of the researcher. It has been acknowledged in this research that the phases of analysis became

increasingly interpretative – which was by design and also reflected an increasingly deep understanding of the interpretive phenomenological project, which culminated in a metaphorical synthesis, epistemologically, this acknowledges variance in level of interpretation across the study.

Evaluation of the Research

The principle strength of this study: its broad exploration of a previously unreported phenomenon of effective OT, is also its weakness. Rather than polarise a discussion into the predictable counter arguments of specificity vs genericism, a more sophisticated level of analysis is offered which recognises that both a broad view and a specific research focus have value with this study. A Polarity Management Analysis (Johnson, 1993) of the benefits of taking both a broad and narrow area of enquiry is visually presented, please refer to Appendix 31. This approach uses ‘both/and’ thinking, instead of ‘either/or’ and can usefully increase performance and productivity. The analysis identifies weaknesses in the research particularly related to the under-representation of community OT participants, profession focus and the challenges of the insider researcher position. The hopes for future research and practice developments, which can have a more focussed area of enquiry, are outlined. The potential downside of narrowing focus is presented with concerns identified in losing the holistic, integrated focus of research in this area, recognition of system wide power differentials and a reductionist view of a complex phenomenon. The optimal state is to coalesce the upsides of both broad and narrow focussed developments, to achieve the higher purpose of sharing an understanding of effective OT, so that the value of it is realised for CYP, families and society.

Conversely, the downsides of both approaches can be used as 'red flags', which indicate when either approach is no longer working towards the vision, and risks realising the deeper fear: that the value of effective OT be lost to CYP and society, due to an inability to share the understanding of what effective OT offers. Combining research skills, clinical practice insights and the application of the management/leadership tools to this research evaluation, provides a unique method of appraising its value, utility and future potential use. It raises the importance of professional doctorates in facilitating research leadership skills, which bridge traditional academia and current clinical practice.

Research Activity to Date

Following successful abstract submission, emerging findings of this study were presented at the College of Occupational Therapists Annual Conference in June 2015.

Reflecting the parity of esteem agenda and the need for greater collaboration between paediatric and mental health occupational therapists undertaking research, a collaborative project was undertaken looking at participation for children with DCD (in press).

Having conducted an exploration of effective occupational therapy from the perspective of the OT and as a child-centred profession, the next logical step was to capture the views of CYP. To this end, the researcher successfully submitted a bid in April 2016 for seed-corn research funding to scope service user-led research into occupational therapy in CYPS.

Future Research Activity

Participatory Action Research Project Proposal

Consequently, a senior OT within CYPS has been funded to be released from clinical duties for a day a week for four months, from September 2016, to allow time for work on a research proposal. This process is to be supported and supervised by a CYP Academic Clinical Collaborative which straddles a two local universities and an NHS Provider Trust. This scoping phase of the research will also be informed by an international specialist in participatory approaches to research. The aim is to have developed a robust bid for more substantial funding by the spring of 2017.

To augment the research arm of this bid, the service user and carer forum of a CYPS in-patient unit have been asked if they wish to contribute to this endeavour. The final research question or research aims will be decided on by service users and the intention is to support CYP to carry out the research with the necessary support and training, thereby offering another element of vocational training for their own future development. There is a need to ensure that such a research endeavour is academically robust and inclusive of children of different ages and abilities. Current service feedback methodologies, which are heavily reliant upon verbal communication, can pose significant issues for children and act as a barrier to their true voice being heard. Inclusive, participatory research methods of eliciting the views of children and young people will be essential to providing and shaping child-centred services in the future.

The findings of this doctoral research will be shared with a CYP service carer group, should they wish to hear about it, and will provide insights from which to contextualise the service-user perspective. The published findings of this study will contribute to the review of relevant literature for this future service user study, which has found that the voice of children and young people in specialist mental health/learning disability services, whilst vocal on social media, is relatively silent in published research.

The Enhancing Occupation: Outcome Measurement Toolkit for Young People (Appendices 23-26) will be offered as a contextual contribution of occupational therapists' perspectives of effective occupational therapy and the embryonic ideas of how to capture patient experience and outcomes. A workshop for CYPS OTs will be offered to share the findings and discuss the utility of the proffered CYPS OT Outcome Measurement Toolkit.

Informing and Influencing the Fields of Occupational Therapy and Occupational Science

Following a successful abstract submission, the findings of this research will be presented at the College of Occupational Therapists' specialist section for Children, Young People and Families (CYPF), annual conference on 11th November 2016, providing an opportunity to share findings across both paediatric and mental health OTs working with CYP and families.

The intention is to share this research at other professional conferences, such as the OT Show (November 2016) and the COT Conference in June 2017. An

article summarising the key professional issues will be submitted to the British Journal of Occupational Therapy.

Occupational Therapists and Occupational Scientists Working Collaboratively

As previously discussed in relation to methodology, having time to study the philosophical depths of phenomenology may be a luxury more accessible to occupational scientists than practitioners. Building closer collaborative relationships between occupational scientists and occupational therapists may be required to facilitate a more honest and open discussion of the difficulties in bridging the academic/practice gap and translation of knowledge (Flottorp et al., 2013) in both directions. The reaching out of occupational scientists to bridge this, and the reaching out of occupational therapists to utilise such insights, is a tangible example of the symbiotic relationship between both, and such a collaboration is likely to produce new and relevant research for service users. Comprehensive study of occupational forms (Hocking, 2009) in various practice environments (such as Tier 4 CAMHS), could valuably be undertaken by occupational scientists invited into the practice context to investigate the use of various occupations as applied to different environments. Thus extending the understanding of such occupational forms, as called for by leading occupational scientists. Sharing this research study at the next Occupational Science Europe (OSE) Network in September 2017, would provide a valuable opportunity to network and create international links. More locally, Northumbria University have created an Occupational Science post

and collaborative links between practice and academia are currently under discussion, which could valuably further research in this field.

Adult and CYP Mental Health OT

Similarly, within the legislative drive to address parity of esteem, there are currently statutory obligations to address the current divide between adult and Child MH/LD. The Equality Act seeks to eliminate age-related discrimination, amongst other things, with government advice specifically stating that:

“There are no specific exceptions to the ban on age discrimination for health or social care services. This means that any age-based practices by the NHS and social care organisations need to be objectively justified, if challenged.”

(UK Government, 2010, p. 1)

Since 2011, the additional Public Sector Equality Duty has required public bodies to advance equality and eliminate discrimination. The findings of this study are in relation to Young People’s Services, which extend up to the age of 18 years. Meanwhile, previous studies of effectiveness in OT have focussed only on adults. Subsequently, between paediatric and adult occupational therapy, which have progressed in developing their research and evidence base, CYPS MH/LD occupational therapy has remained at the periphery of research interest. In the light of the Equality Act 2010, and subsequent Public Sector Equality Duty, there rests with public sector occupational therapists the duty not to disadvantage CYP by virtue of their age, a position which this research provides objective justification by which to support a challenge to practice to date. On the part of CYPS researchers, equally, those over 18 should not be disadvantaged. The findings of this study resonate with those

identified in the Adult OT study (Wimpenny et al., 2014), and collaborations will be sought with these authors on future worldwide meta-analysis of effective occupational therapy in mental health to include under eighteens.

Influencing Decision Makers

By bridging traditional thresholds with paediatric OTs, adult mental health OT researchers and occupational scientists would significantly support the advancement of research and practice development in CYPS MH/LD occupational therapy. Such collaborations would progress the ability to influence decision makers by sharing insights, combining resources and producing high-quality research outputs. Left to CYPS OTs under considerable operational pressure from under-resourced, performance-driven commissioning, with little research infra-structure, effective occupational therapy in this area of specialist clinical practice is likely to be a largely unknown and misunderstood phenomenon. The principle recommendation from this research will be for the United Kingdom Occupational Therapy Research Foundation (UKOTRF) division of the College of Occupational Therapists to support a dedicated research study aiming to build the evidence base for CYP's occupational therapy. By increasing research capacity to develop suitable outcome measures, such support would enable CYPs OTs to capture and share the results of effective occupational therapy. Consequently, the value of addressing the occupational needs of CYPs with complex MH/LD, as a route to improving their health and wellbeing (Wilcock), would be better understood as an alternative to medical/behavioural solutions to children's presenting problems. UKOTRF applications for Research Priority Grants are

invited from October for submission by 13 January 2017, which would allow time for a collaborative research bid to be developed and put forward for consideration. A clinical academic professor has offered mentorship for such a research endeavour. Longstanding collaborative relationships with key mental health researchers in occupational therapy would be called upon to establish a suitable lead applicant and supporting team, with requisite methodological experience. Employer support has been sought and granted for an honorary contract with a local university to progress AHP-related research activity, with allocated time of a day a week from September 2016.

Summary

The impact of this research has been demonstrated through peer reviewed abstracts which have led to sharing early findings at the College of Occupational Therapists Conference 2016, with further planned dissemination via other professional fora in 2016/17. A service user-led project has received seed-corn funding and aims to submit a bid for substantial NIHR grant funded participatory action research in 2017, supported by occupational therapy. To address statutory requirements for equality (UK Government, 2010) and parity of esteem (NHS England, 2013a), efforts to bridge CYP's OT with paediatric (under discussion), adult MH (established collaborations), and occupational science (under discussion) will be sought to further the CYPS research agenda within the wider contexts offered by other occupationally-focussed specialisms. The intention is to submit a collaborative research bid to UKOTRF for funding to establish relevant outcome measures for CYPS which will enable

key decision makers (including therapists) to be provided with the necessary tools by which such interventions can be judged as to their effectiveness.

Conclusion

Satisfying the research objectives related to contributing to knowledge and practice, this chapter has reported on how the study findings apply to research and occupational therapy. Firstly, use of the overarching framework of the Occupational Perspective of Health (Wilcock and Hocking, 2015) was recommended, with the advantage of a unifying clear vocabulary to enhance the articulation of the role and impact occupational therapy. To a lesser extent, the use of the International Classification of Functioning (ICF) by CYPs OTs to support CYP to achieve greater levels of health through enhancing participation was shown to require further investigation in collaboration with insights from paediatric OT who have already advanced practice in this field.

A CYPs Outcome Measurement Toolkit has been offered which differentiates between patient- and clinician-reported experience and outcome measures. It focusses on enhancing the four areas identified in the Occupational Perspective of Health (OPH): doing, being, becoming and belonging. This research provides a reference point of current best available evidence. The aspiration of the toolkit is that it contributes to a baseline assessment of current practice, against which OTs can critically appraise their work and develop their clinical reasoning skills, and the articulation of them. By evaluating services in terms of improving quality of life and outcomes for children, OTs will be responding to statutory requirements set out by CQC (Care Quality Commission, 2016a), HCPC (Health Care Professions Council, 2016, Health Care Professions Council, 2012) and COT (College of Occupational Therapists, 2011) to provide effective occupational therapy.

Key areas of specific learning for OTs in practice have been identified and links across paediatric care and adult mental health care recommended. The importance of influencing decision makers and the research agenda in this field has been articulated. The hope is that this research may contribute to future clinical practice and research development, which ultimately results in more effective occupational therapy provision which enables young people to become healthier through the enhancement of their occupational being (Wilcock and Hocking, 2015).

Chapter Eleven: Conclusion

Introduction

This concluding chapter will draw together the two main strands of this thesis: the identification of a research problem requiring planned investigation and the resultant findings following detailed enquiry, analysis and synthesis and the implications for occupational therapists working in this specialist area.

A professional practice issue was identified in the light of regulatory requirements that children and young people receiving specialist mental health/learning disability services in NHS England be provided with effective occupational therapy. Having identified the area of concern and explained the nature of the clinical climate for children accessing these services, the context within which such services was provided. The research aim and supporting objectives were given, along with an honest account of the rationale for conducting such a study, which sought to bridge both academic and practice developments for occupational therapy in children services. Relevant NHS policy, legislation and literature was identified which honed and explained the reasoning behind the research aim. Methodological choices were explained and a study designed which endeavoured to robustly address key concerns and expose a previously hidden phenomenon.

The second strand of this thesis reports on how the research blueprint was translated into robust fieldwork. Capturing the lived experience of occupational therapists working in children's mental health and learning disability services, highly descriptive examples of effective occupational therapy were recounted, recorded, transcribed and analysed, in order to examine this phenomenon. Using a range of analytic methods, the written data were thoroughly explored,

foregrounding different aspects through the application of increasingly interpretive methods. Consequently, a myriad of thematic insights were identified, culminating in a visual synthesis which provided a systematic and integrated analysis of findings, grounded in the data provided by OTs working directly with children. From this fertile ground, a range of recommendations and discussion points were proffered and plans for future practice and research developments outlined.

This research has been important in bringing to light the phenomenon of 'effective occupational therapy with CYP with MH/LD, as lived by occupational therapists. In the absence of other such studies, the phenomenological methodology combined with robust implementation of methods has provided a powerful route to exposing previously hidden clinical practice. By so doing, the aspiration is for other CYP to benefit from receiving such services, and that those providing these interventions are attending to their professional responsibility to consider whether they are effective.

Summary: Research Problem, Design and layers of Analysis

Child mental health has moved into the spotlight of political awareness since being a priority for the coalition government and as commissioned services reported on increasing levels of referral, acuity and an ever-increasing gap between demand for services and capacity to respond to clinical need. New legislation was put in place to ensure that Parity of Esteem was a requirement across health and social care. The new NHS Health and Social Care Act 2012, established NHS England as commissioners of services, with a focus on outcomes and supporting the voice of patients to influence services as a result

of their feedback on experience and their outcomes. Increasing levels of scrutiny and regulation via the Care Quality Commission, on behalf of the NHS, was strengthened in the light of Mid-Staffs Inquiry (House of Commons Library, 2013) and other high profile failures in NHS services to adequately, or effectively, meet the needs of patients.

The College of Occupational Therapists and the Health Care Professions Council responded to concerns about professionalism with revised standards of conduct (Health Care Professions Council, 2016, College of Occupational Therapists, 2015, College of Occupational Therapists, 2011) . Occupational therapists, as autonomous practitioners (World Federation of Occupational Therapists, 2007), were required to meet these revised standards and declare competency through self-regulation. Despite a lack of unifying definition, a review of such initiatives identified a coalescing call to ensure practice was effective. How would occupational therapists assess their practice as being effective without a baseline from which to compare? How would OTs know which outcome measures to use, if the salient attributes of effective OT had never been captured? Would such measures capture the thing that made OT most effective? How would they teach under-graduates and newly qualified staff how to be effective?

Methodology

This study was designed to capture the current picture of effective OT. Seeking exposure of a current phenomenon, describing what is happening, called upon a phenomenological methodology. Recognising that, as an insider researcher

occupational therapist hearing descriptions from occupational therapists, a level of interpretation was inevitable from the outset. This process involved capitalising on the upside of such an insider position and building on insights from psychodynamic psychology, and utilising clinical skills as a researcher to engage, draw out, put at ease and co-create. To have a reflexive relational approach with participants, or co-researchers, was a liberating aspect of methodology. Embracing an interpretive stance brought to the research an understanding and hermeneutically artistic element.

Research Aim & Objectives

Establishing a clear and simple research aim to explore the phenomenon of effective OT with CYP provided a grounding clarity for research and participants alike. Supporting objectives spawned a qualitative interpretive study, wanting to capture the lived experience of OTs working in this specialist area. An interpretive approach was chosen, which called upon a range of methods. Ultimately, the objective was to contribute to the body of knowledge and suggest next steps for practice and research.

Method

Following ethical approval from both the university and NHS Trust, an advert was sent out inviting OTs working in community or in-patient specialist services for CP with MH/LD, to make contact if they wished to be involved. This purposive sample of occupational therapists was realised through OTs responding to the advert and making contact with the research administrator,

who arranged for participant information sheets (PIS) and consent forms to be sent out prior to individual interviews. Participants provided written consent and interviews were digitally recorded with permission. Following interviews, OTs were provided with a debrief advice sheet and all requested to hear about the final study. Several participants remained in contact and asked about progress over the ensuing years. Five distinct data analysis methods were used to investigate the phenomenon: thematic; metaphorical; Lifeworld; OPH; and reflexive.

Data Analysis – Five methods:

Themes

Using both inductive thematic analysis and Ashworth's (Ashworth, 2003) Lifeworld fragments provided a framework within which to explore the data from different perspectives. This resulted in significantly different aspects of OT being foregrounded, as would be hoped for in an interpretive phenomenological study.

The phenomenological descriptive analysis (PDTA) revealed four main areas underpinning effective occupational therapy. Firstly, it found that adopting a child-centred approach, engaging the child and accepting them for who they are was an important first step. The approach of the OT and their beliefs emerged as a second theme, emphasising the need to build a trusting relationship, assuming a non-judgemental approach and being tenacious in the face of difficult sessions. Thirdly, the meaning and use of time to convey consistency, regularity and providing space for the child to use the session

how they wished. Fourthly, OT practice was described as providing meaningful activity, via the use of grading and positive risk taking.

Metaphorical

The other aspects of the PDTA analysis related to the themes which emerged from the metaphors used, including notions of: managing obstructions (jumping hurdles), creating flow (opening canal locks), learning and growth (blossoming flowers, turning sparkling lights on), experiencing highs and lows (roller-coaster) and providing CYP with containment (jointly woven basket).

Lifeworld

Ashworth's seven Lifeworld fragments provided a surprisingly different view of the data. Inter-related complexities emerged from this analysis. Initially coded in a unified manner, it became apparent that the occupational therapists' projects were quite different to that of the young person, as described by the OTs. Eliciting the views of CYP directly was beyond the scope of this project, though important differences emerged from the OT's descriptions. Emerging from the Lifeworld analysis was the pivotal issue of developing the CYP self-hood, their sense of agency and identity, through projects or activities they were committed to. Aspects of spatiality and sociality identified the importance of the environment and the relationship to the success of the self-hood endeavour.

Occupational Perspective of Health (OPH)

Through initial presentation of the findings, it became apparent that the OPH would provide a valuable contextual touchpoint for emerging findings. Rather than do this in a sporadic, organic way, it was decided to explore whether coding the thematic and Lifeworld themes against the OPH framework would provide any further insights. Two key issues emerged: in relation to OPH terminology and regarding occupational justice as being in the domain of occupational therapists.

Reflexivity

Reflexive analysis using Finlay's (Finlay and Gough, 2003) three stages of pre-research, data gathering and data analysis were used to structure the more granular analysis of varying levels of collaborative reflexivity. The primary purpose of this endeavour was to allow the reader to critically appraise the trustworthiness of the data (Lee, 2009) and offer a transparent account of the researcher position (Guillemin and Gillam, 2004, Pillow, 2003). As the next part of this chapter unfolds, it is perhaps salient to suggest that Finlay's model could valuably be extended to include the discussion/recommendations stage, which are inevitably influenced by the researcher's own agenda. In an effort to maintain a transparent account, issues around offering an outcome measurement toolkit and suggesting methods by which OTs can influence decision makers are made explicit in recommendation chapter introductions. This reminds the reader of early stage motivations to encourage OTs to use outcomes in order to influence commissioners and others as to the utility of their services, in the hope of gaining investment to expand OT provision for

the benefit of the young people we serve. It is offered not as a confession but rather to acknowledge the methodological roots of the reflexive relational approach, which seeks to co-create understanding and meaning. It also celebrates the value of the professional doctorate, which seeks to straddle academia and practice as a root for knowledge translation. As policy, legislation and literature impact findings, they provide the real world context of how professionals deliver therapeutic services and the routes towards maintaining excellence in a challenging health economy.

Summary: Research Findings, Wider Context and Recommendations

Discussion

The visual synthesis of findings using the image of a flower, grounded in occupational justice and fed by occupation, enabled the interactive complexities of the primary findings to be discussed.

Within the first of the OPH themes, being, it became evident that there were shortfalls in how this concept, defined from a health perspective, actually translates to CYP MH/LD. The findings of this study place the notion of being as central, carrying with it an element of occupational existentialism which was not evident in Wilcock's conceptualisation and explanation of fundamental constructs. Similarly, the health-orientated concept of belonging described by Wilcock is a far cry from the lived experience of OTs when describing CYP in an in-patient environment. Identifying social connectedness in highly-disrupted childhoods or neurodevelopmental presentations such as autism can be

problematic and stands aside of Wilcock's utopian description of 'feeling right and fitting in'.

Secondly, occupational justice appears to be a highly relevant concept in relation to effective occupational therapy with CYP, especially within MH/LD in-patient facilities. The WFOT Position Statement on Human Rights directly challenges OTs to accept responsibility to personally identify and address injustices and limit the impacts of it on individuals. OTs in this specialist area described addressing occupational imbalance, alienation, deprivation and marginalisation. In particular, OTs have led on addressing the occupational alienation experienced by CYP who may need the reassurance of therapeutic touch. Similarly, in this study an OT spoke up for the right of young people to have the support of clinical expertise to weigh up a decision pre-disclosure, which in adulthood would be supported. OTs may consider the use of legislation, for example the Equality Act (UK Government, 2010), to address this injustice as life-changing for some young people who struggle to know what to do when safeguarding legislation no longer works to provide peace of mind. Finally, in addressing the needs of children who process information more slowly and need more time in therapy, therapists may consider use of the Equality Act (2010) to seek reasonable adjustments to contracted sessional time, in order for CYP to receive the service they need, where their disability precludes them from fast-track services and time-limited interventions.

It was a surprising outcome of this study to realise how political the profession is, and may become (Pollard and Sakellariou, 2012), from an occupational justice perspective. Breaking out from an individualised focus of therapy, OT,

as agents of change, are assuming a broader political role in civic and community occupational justice. As OTs struggle to articulate their role, perhaps by articulating the occupational rights of children, their message will be heard and their occupational roots be more apparent. Participants described OT as providing an alternative perspective and, indeed, the occupational basis of OT provides a unique perspective, in an otherwise dominantly medicalised health environment. Embracing the five key findings of this study, OTs describe occupational therapy being effective when it is child-centred, based on an authentic relationship, and providing time and space to the child in which they can develop their sense of self-hood and autonomy, which is in itself facilitated by expert activity and environmental micro-grading.

The summative metaphor of the rollercoaster ride was an interpretation of all the themes and insights gained in this study. It emerged from the embodied understanding of the phenomenon, which was activated at the transcribing phase, as detailed in the reflexive account, and developed during the increasingly interpretive stages of analysis and synthesis. It was shared with a participant for a first response and received the 'phenomenological nod'. A second participant has also responded enthusiastically to it and accepted the rap version, on behalf of and for the use of children on an in-patient unit.

Recommendations

Having met all six of the objectives, which support the realisation of the aim to explore the phenomenon of effective occupational therapy, this research has comprehensively explored the phenomenon through the use of a multiplicity of approaches. Clearly, however, it is a modest contribution to the understanding of what constitutes effective OT with CYP, and provides a small step in building a greater understanding of a little known phenomenon.

Nevertheless, it is ethically important to share the findings and help develop practice. Therefore, in the spirit of this, an outcome measurement toolkit is offered which is based on the insights of the participants of this study. It is not a definitive guide but a starting point for a pilot, from which other CAMHS/CYPS occupational therapists can reflect on their own service and will be invited to join an effective CYPs OT network.

The toolkits utilise the OPH, which, despite its explanatory shortcomings, remains sufficiently relevant to warrant its use as a framework for therapists. This too is subject to further consideration and debate. Does the OPH focus on health render it less useful to the applied field of occupational therapy than the academic field of occupational science? However, much of the recommendations from this study suggest collaborations and joint working with paediatric OT, adult mental health OT and between occupational scientists and occupational therapists.

Interconnectivity provides a pragmatic solution to building solutions together in partnership. Currently, the NHS in England is re-structuring strategically around Sustainability and Transformation Plans (NHS England, 2015) in an

effort to meet population needs and improve efficiency. Responding within the same financial climate, it behoves therapists to collaborate to maximise the benefit of collective responsibility to improve the lot of CYP accessing NHS specialist MH/LD services.

Recommendations in relation to research relate to the dissemination of the findings from this study and the plans to apply for funding from COT R&D in order to progress the outcome measurement aspect of this research.

Conclusion

This chapter has explained the two main strands of this thesis: the identification of a research problem and detailed plan to research it and the implications of the findings for occupational therapists working with young people. NHS policy, legislation and literature were identified and explained the reasoning behind the research aim. Methodological choices were explained and a study designed which endeavoured to expose a previously hidden phenomenon and address the principle concerns.

Execution of the research plan, based on a clear methodology and congruent analytic methods, have satisfied the research aims and, in so doing, have contributed to the body of knowledge in this area and the development of clinical practice in occupational therapy with children with MH/LD.

Solutions to addressing the identified regulatory and professional practice issue have been offered by way of a range of outcome measurement

toolkits, as a starting point to developing a baseline against which practice can be calibrated.

The main thematic insights identified were presented in a visual synthesis, which provided a systematic and integrated analysis of findings. Plans for future practice and research developments have been outlined, along with an ontological and epistemological analysis of the weaknesses of the research. This research has brought to light the phenomenon of effective occupational therapy with CYP with MH/LD, as lived and understood by occupational therapists. The hope is that other CYP benefit from receiving effective occupational therapy and that those providing these interventions are attending to their professional, legal and ethical responsibility to ensure that they remain effective.

Quote:

Cath: 'When I told him he was the expert in himself, he just cried, no-one ever said I was an expert in anything...'

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**OCCUPATIONAL THERAPISTS:
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THE PHENOMENON OF EFFECTIVE
OCCUPATIONAL THERAPY WITH
CHILDREN AND YOUNG PEOPLE**

M P Quinn

DOccTher
September 2016

Volume 2 of 2

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M P Quinn

A thesis submitted in partial fulfilment of the
requirements of the University of Northumbria at
Newcastle for the degree of Professional Doctorate

Research undertaken in Health & Life Sciences: Health
& Wellbeing

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Appendices

Appendix 1: List of abbreviations

Abbreviation	Description
ADHD	Attention deficit hyperactivity disorder
AHP	Allied Health professional (OT, Physiotherapy, Speech Therapy, Dietetics etc., registered with HCPC)
ASD	Autistic spectrum disorder
AQP	Any qualified provider
CAMHS	Child and adolescent mental health services
COPM	Canadian occupational performance measure
COT	College of Occupational Therapists
CREMS	Clinician reported experience measures
CROMS	clinician reported outcome measures
CQC	Care Quality Commission
C&YP or CYP	Children and young people
CYPS	Children and Young People Services (CAMHS plus mild/moderate Learning Disability)
DCD	Developmental Coordination Disorder
ED	Eating disorder
FYFVMH or 5YFVMH	Five Year Forward View for Mental Health
HCPC	Health Care Professions Council
ICF	The International Classification of Functioning, Disability and Health
LD	Learning Disability

MH	Mental Health
MH/LD	Mental Health/Learning Disabilities – interchangeable terms, describes population serviced by the service, CYP will have a mental health problem and may have a secondary LD. Commonly there is a behavioural presentation which can have aspects of both issues. Includes neuro-developmental problems associated with ASD and ADHD.
NDPT	Non directive play therapy
NHS	National Health Service
NHSE	National Health Service England
OPH	Occupational Perspective of Health
OT	Occupational therapy
OTs	Occupational therapists
PAR	Participatory Action Research (PAR) methodology
PROMS	Patient reported outcome measures
PREMS	Patient reported experience measures
QNIC	Quality Network for Inpatient CAMHS
SH	Self harm
ICF	International classification of functioning
WHO	World Health Organisation
MOHO	Model of Human Occupation
NDPT	Non-directive play therapy
Tier 1	GP
Tier 2	primary care targeted services
Tier 3	Community specialist CYPS

Tier 4	In-patient highly specialist CYPS, either mainstream (MH/LD) or Forensic MH/LD (low, medium, high secure) Forensic
WHO	The World Health Organisation
ICF	the International Classification of Functioning
ICD	International Classification of Diagnosis (eg ICD 10)
WFOT	World Federation of Occupational Therapists

Appendix 2: Ethics Approval Submission: A Critical Appraisal of Insider Position

Excerpt from unpublished research proposal – 24 th April 2013.	Mitigation for ethical issues
<p>“I have reflected on my insider researcher position and applied Linda Finlay’s call for reflexivity and “outing the researcher” (Finlay, 2002b). I have specialised as a CAMHS OT for the past 22 years, undertaken Masters level research into the clinical reasoning of CAMHS OTs in order to improve clinical effectiveness. I consider OT to be an important intervention to aid the recovery and well-being of children suffering with MH problems.”</p>	<ul style="list-style-type: none"> • Power differentials: My current role as CYPS AHP Lead and Clinical Director for AHPs means I do not come into regular contact with the majority of clinical staff in CYPS. • Potential for coercion: I directly supervise the Head of OT in community CYPS and the AHP Services Lead in CYPS In-patient services and as direct reports; they will be excluded from being invited to participate in the study. • Potential for Coercion: Clearly staff will need assurance that their involvement be entirely voluntarily, with an invitation to staff with clear expectations, with assurance of no adverse effects to them or the service of being involved or not. • General verbal discussions with MDT/managers, will reiterate the voluntary nature of the study. • Potential for Coercion - Another member of staff will assist with recruitment, once initial invitation to participate and the associated PIS has been sent out, there will not be direct verbal contact from me to potential participants, unless specifically requested. • Pre-conceptions regarding what effective OT is: an explanation of the methodology will explain that the study is designed to capture the lived experience of OTs, and that there are no wrong answers.
<p>“I have a strong drive to improve practice, having specialised in the governance of the profession for over 15 years, and for OTs to be as</p>	<ul style="list-style-type: none"> • Boundaries of confidentiality & Power differentials: Organisational role in relation to governance. Assurance provided in Participant

<p>clinically effective as possible and to make the biggest difference to children and to focus finite resources efficiently. My drive is for effective marketing of OT & identification of their USPs”.</p>	<p>Information Sheet (PIS), that my role is as researcher.</p> <ul style="list-style-type: none"> • Clarity provided in PIS, prior to participant being interviewed, regarding confidentiality and what will happen where disclosures are made (e.g. in relation to malpractice or Vulnerable Children), in relation to University and Professional guidelines. • Objectivity/subjectivity: Active use of critical self-reflection, use of reflexive journal, research supervision and feedback, will enable the researcher issues to be foregrounded in the method and underpins the choice of methodology and approach. • Aim is to maximise the research advantages of both the objective and subjective positions and provide relational centred research data for analysis and transparent evaluation of the rigour of the overall study. • Dissemination of findings - Evidence of the professional-doctoral nature of the study and relevance to practice, mitigated by robust academic process and rational.
<p>“Having been the first OT to be awarded a Health Foundation Leadership Fellowship and a national exponent in OT and AHP communities, for the importance of transformational clinical leadership in practice, I believe this approach is just as important in research as in clinical practice. Part of transformational leadership is the use of political Influencing skills”.</p>	<ul style="list-style-type: none"> • Political Influencing/objectivity- as above. In addition, the principle route of influencing is through robust academic study and dissemination of findings – as required by Doctoral level study. • Original proposal reviewed to reduce managerial agenda regarding outcome measurement • Revised proposal enhances academic rigour of study and focuses on the phenomenon and the lived experience of it, by OTs. • Dissemination of findings – through publications - anonymity assured for participants – explained in PIS, ensuring participants are aware of this prior to agreeing to be involved. • Dissemination of findings – within the service - anonymity assured for participants – explained in PIS,

	ensuring participants are aware of this prior to agreeing to be involved.
<p>“As a Neuro-Linguistic practitioner (NLP), I am interested in language and how people have different maps of the world which potentially and often lead to the distortion, deletion, insertion of understandings attributed to sensory data. Having received training as a coach, mentor, facilitator, educator and trainer with significant experience, I believe I have the researcher skills to facilitate active participation of CAMHS Ots in the research process, where colour pens, glitter and a pritt stick are invaluable tools with a naturally creative articulate group used to using multiple modes of communication”.</p>	<ul style="list-style-type: none"> • Objectivity/subjectivity - Research methodology revised to capture and foreground the relational centred research method, supported by robust reflexivity, use of this data in analysis and synthesis of material. • Clarify sources of data collection – explicitly stated in PIS that data gathered from in-depth one to one interviews, with possible phone or face to face, 1:1 follow up, for clarification as necessary. • Chosen interpretive phenomenological approach allows for a human sciences approach to both the art and science of research and its resonance with the art and science of OT. • NLP - use of clean language techniques, made clear in questioning schedule for ethical approval – purpose it to minimise researcher influence. • Power differentials - Researcher approach – to assume the phenomenological attitude, to bracket pre-conceptions, to identify pre-conceptions via reflexive journal, to approach research encounter with presence, respect and openness to listening to participant, with curiosity and wonder.

Appendix 3: Gantt Chart

Fieldwork

Action	Details	Deadline	4/14	5/14	6/14	7/14	9/14	10/14	11/14	12/14	1/15	2/15	3/15	4/15	5/15	6/15	7/15	9/15	10/15	11/15	12/15	1/16	2/16	3/16	4/16	5/16	6/16	8/16
Preparation	Ethical Approval																											
	recruitment flyer																											
	Send Participant Info leaflet																											
	contact participants																											
	Diary 1:1 Interview dates	Total 8-15 interviews																										
	Book room																											
	ID any Equality Act adjustments																											
	Confirm interview																											
	Book recording equipment																											
	Additional 1:1's, date, venue	March 2015																										
	Date, time and venue																											
	creative materials	Collate																										
Action	Details	Deadline	4/14	5/14	6/14	7/14	9/14	10/14	11/14	12/14	1/15	2/15	3/15	4/15	5/15	6/15	7/15	9/15	10/15	11/15	12/15	1/16	2/16	3/16	4/16	5/16	6/16	8/16

[illegible]

Appendix 4: Participant Information Sheet

Project Title	<i>“Occupational therapists: Their Lived Experience of Effective Occupational Therapy with Children & Young People”</i>
Principal Investigator	Maria Quinn (Email: Maria.Quinn@northumbria.ac.uk)
Supervisor	xxx (Email: xxx@northumbria.ac.uk)
Invitation	<p>I would like to invite you to take part in this research study. Before you decide, I would like you to understand why the research is being carried out and what it would involve for you. I will go through the information sheet with you and answer any questions you have. Ask us if there is anything that is not clear.</p> <p>The project is part of a professional doctoral research study looking to capture the views of CYPS (CYPS: Children and Young Peoples (integrated mental health/learning disability) Services) Occupational Therapists. I would like you to consent to participate in this study as I believe that you can make an important contribution to the research. This interpretive phenomenological research will take a relational-centred approach (Finlay and Evans, 2009) , which requires the investigator to bracket assumptions and allows for the co-creation of data – in a spirit of openness and empathy (Finlay, 2011).</p>
Purpose	<p>Explaining what effective Occupational Therapy is, in the clinical field of CYPS is a challenge, with no service specific studies in the professional literature.</p> <p>I wish to explore OT’s views of what is effective in terms of benefit to C&YP, in order to further our knowledge and understanding of what effective Occupational Therapy is, in this clinical area. If we can identify those things that make OT effective, it may help to make OT with C&YP increasingly effective. Ultimately it is the desire to provide the most effective OT for C&YP, to help improve their occupational performance and quality of life, which underpins this study. Unfortunately, due to time and practical constraints, this study will not be seeking the views of children, though this is an important consideration for future study.</p> <p>The literature tells us that the perception of OTs of what is effective, is an important indicator of the therapy options chosen. Consequently, this study will focus on giving voice to the experience of occupational therapists, with the lived experience of the phenomenon of what is (and is not) “effective occupational therapy” with Children and Young People.</p> <p>In bringing together and comparing rich descriptions of these perceptions of what is effective OT with children, it may be possible to identify particular core features – or essence(s) – of what OT with CYP is.</p>

Why have I been invited to take part?	Because you are an OT working with children and young people.
What will I have to do?	<p>It is up to you to decide if you want to take part in the research.</p> <p>You will be asked to attend for a face to face in-depth interview, held on NTW premises (at a location that suits you), between July 2014 and March 2015.</p> <p>On attending this session you will be met by me and allowed to ask any questions. I will describe the study and go through this information sheet with you. If you agree to take part, I will then ask you to sign a consent form.</p> <p>The interview will be tape recorded, and later transcribed into text form. Recordings of interviews will be deleted upon transcription. You would be very welcome to a copy of the final report.</p> <p>As part of the presentation of results, your own words may be used in text form. This will be anonymised, so that you cannot be identified from what you said. All of the research data will be safely stored at Northumbria University in electronic form, on the U Drive.</p> <p>Please note that:</p> <ul style="list-style-type: none"> • You can decide to stop the interview at any point • You need not answer questions that you do not wish to • Your name will be removed from the information and anonymised. • If you would like to be involved, but not tape recorded, you are still welcome to participate and we can discuss how we capture your views in a way that feels comfortable, when we meet. <p>The investigator will ask you about your experience of effective occupational therapy in CYPS. You are not being asked to analyse this experience, just to describe it, so no preparation is needed by yourself.</p> <p>After you have completed the interview I will give you a Debrief Advice Sheet explaining the nature of the research, how you can find out about the results, and how you can withdraw your data if you wish.</p> <p>It is estimated that the total time to complete this interview will be 45-90 minutes. Although unlikely, you may be asked to attend a second interview, if further clarification is needed, which would take no more than 30-40 minutes.</p> <p>If you would like to hear about the preliminary findings and participate in a follow up group session to comment on the data analysis, you would be very welcome. This involvement is optional of course and you can decide to be involved in this or not.</p>
What is the exclusion criteria (i.e. are there any reasons why I	We would like to include a range of OTs varying in experience, area (community, in-patients, forensic), approaches and geography.

should not take part)?	Consequently, depending on response rates, there is a possibility that having expressed an interest, you may not be selected. The decision as to who will be selected will be with the principle investigator, using a specific Strategic Sampling strategy. You will be notified within 2 weeks of the deadline of expressions of interest, whether you have been selected or not.
Will my participation involve any physical discomfort?	<p>It is not intended or anticipated that you will feel any physical discomfort in this study. Naturally, should you need a comfort break during the interview; this can be easily accommodated at the time. Should you have specific needs in relation to a health condition, the investigator will be happy to accommodate them, please communicate these prior to the room being booked, so that arrangements can be made to facilitate your involvement and maximise your comfort.</p> <p>All procedures involved in the study are required to be risk assessed and this information is provided as part of the ethical approval process, which was undertaken prior to this study being able to start.</p>
Will my participation involve any psychological discomfort or embarrassment?	<p>Talking about our experiences in our professional roles can sometimes be upsetting. Should you need any support during or afterwards, this will be made available to you. Conducting the study within NTW does allow for Trust resources such as supportive supervision, staff counselling and occupational health, to be made available if needed.</p> <p>It is not intended or anticipated that you will feel any discomfort, the project having been risk assessed for ethical approval.</p> <p>Please be assured that it is absolutely OK, if you prefer not to be involved and such a decision will not have any adverse consequence on you. The fieldwork administrator will act as first point of contact and will be happy to provide more information, so you feel reassured whatever you decide to do. Thank you for considering the request.</p>
What methods will you use to find out about my experience of effective OT?	<p>You will be asked to describe your experience of effective OT with C&YP. This is your time to talk about your experience and, in a spirit of support and collaboration, I may prompt you to consider things like the environment, what was happening, what you did and any beliefs or values you have about effective OT.</p> <p>Towards the end, I will offer you the opportunity to sum up your description. This can be as creative as you wish, from just a few key words or by using a metaphor – a process I can facilitate using some simple prompts. This could lead to offering a range of metaphorical descriptions of the essence of “effective OT”.</p> <p>If you are feeling very creative you could refer to/make up a song, poem or Rap or draw a diagram or picture, which captures your experience.</p> <p>This creative aspect is, of course, optional and reflects the doing nature of OT, where some people prefer activity to words. It also reflects the creative aspect of using interpretive phenomenology – which encompasses both the art and science of research.</p>

	These are different ways in which we hope to capture the essence of what effective occupational therapy with Children is, from your perspective as an OT.
How will confidentiality be assured?	<p>The research team has put into place a number of procedures to protect the confidentiality of participants. Including:</p> <p>You will be allocated a participant code that will always be used to identify any data that you provide. Your name or other personal details will not be associated with your data, for example the consent form that you sign will be kept separate from your data. Only the research team will have access to any identifiable information; paper records will be stored in a locked filing cabinet and electronic information will be stored on a password-protected computer. This will be kept separate from any data and will be treated in accordance with Northumbria University research and ethics guidelines (University, 2013-2014)</p> <p>Everything you say/report is confidential unless you tell us something that indicates that you or someone else is at risk of harm. We would discuss this with you before telling anyone else.</p>
Who will have access to the information that I provide?	Any information and data gathered during this research study will only be available to the research team identified in the information sheet. Should the research be presented or published in any form, then that information will be generalized (i.e. your personal information or data will not be identifiable).
How will my information be stored / used in the future?	All information and data gathered during this research will be stored in line with the Data Protection Act and will be destroyed following the conclusion of the study. During that time the data may be used by members of the research team only for purposes appropriate to the research question, but at no point will your personal information or data be revealed.
Has this investigation received appropriate ethical clearance?	<p>Yes, the study and its protocol received full ethical approval from the Northumbria University Ethics Committee on the 1st July 2014.</p> <p>A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and wellbeing of participants and researchers.</p>
Will I receive any financial rewards / travel expenses for taking part?	<p>Sorry, there are no financial rewards for participation.</p> <p>However, the Trust has agreed for CYPS OT staff to participate in this study and has been informed of the time out from clinical services, which this will involve. The investigator will endeavour to arrange interviews close to the participants' work place or at a suitable alternative venue agreeable to the participant. Staff will be able to claim travel expenses should this involve travel to another Trust venue.</p>
How can I withdraw from the project?	You can withdraw any time up to the submission of the thesis. The research you will take part in will be most valuable if few people withdraw from it, so please discuss any concerns you might have with the investigators. Be assured that as all data are anonymised, your individual data will not be identifiable in any way.

	During the study itself, if you do decide that you do not wish to take any further part then please inform one of the research team as soon as possible, and they will facilitate your withdrawal and discuss with you how you would like your data to be treated in the future.
How will the results be disseminated?	<p>The dissemination strategy is to publish the study in peer reviewed journals or may be presented at conferences, within the fields of: mental health and learning disability, the profession of occupational therapy/Allied Health Professions, and within the phenomenological research community.</p> <p>Consideration will be given to the best methods to inform children and young people of the findings. Be assured that however the findings are shared, the data will be generalized, and that your data/personal information will not be identifiable.</p>
How will the results be used?	The results will be made available for consideration by service users and the professional community and recommendations made for future study. For example, to have a service user focussed study of what they perceive as effective OT. By way of reassurance, this is not part of a service improvement plan, nor is it related to performance management in any way.
If I require further information who should I contact and how?	<p>Further questions – please contact one of the research team :</p> <ul style="list-style-type: none"> • Maria Quinn (Email: Maria.Quinn@northumbria.ac.uk) OR • xxx (Email: xxx@northumbria.ac.uk) • Administrator (Email: xxx@xx.nhs.uk) • Transcriber <p>To register a complaint:</p> <ul style="list-style-type: none"> • Dr xxx (Email: xx@northumbria.ac.uk) OR • Dr Nick Neave, Head of Ethics, Faculty of Health and Life Sciences (Email: Nick.Neave@northumbria.ac.uk) <p>To withdraw data:</p> <ul style="list-style-type: none"> • Maria Quinn (Email: Maria.Quinn@northumbria.ac.uk) OR • xxx (Email: xxx@northumbria.ac.uk)

References

- FINLAY, L. 2011. *Phenomenology for therapists: researching the lived world*, Chichester, Wiley-Blackwell.
- FINLAY, L. & EVANS, K. 2009. *Relational-centred research for psychotherapists: exploring meanings and experience*, Malden, MA, J. Wiley.
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Appendix 5: Debrief Advice Sheet

Project Title	<i>“Occupational therapists: Their Lived Experience of Effective Occupational Therapy with Children & Young People”</i>
Principal Investigator	Maria Quinn (Email: Maria.Quinn@northumbria.ac.uk)
Supervisor	Dr xxx (email: xxx@northumbria.ac.uk)
What was the purpose of the project?	<p>This study will focus on giving voice to the experience of occupational therapists, to explicate the lived experience of the phenomenon of “effective occupational therapy” with Children and Young People.</p> <p>Using an interpretive phenomenological approach allows for both the art and science of occupational therapy to be captured. The first stage is analysing the descriptions of effective OT, provided by participants. The data will be interpreted using a number of lenses –firstly using a LifeWorld approach (Finlay, 2011), which will give an existential dimension to the findings. Then the data will be looked, in search for the essence(s) (Van Manen, 1997b) of what effective OT is, with this client group.</p> <p>The Finlay and Evans (2009) relational centred research approach will be taken, where the researcher-participant relationship is explicitly examined. This premise acknowledges, and embraces the fact, that a researcher-participant relationship is two way and that experienced clinical communication and relational skills are useful to foster an “openness... with curiosity, empathy and compassion” Finlay (2011, p.166), thereby enabling the co-creation of data. Key to the success of this approach is the researchers’ reflexive skills, where critical self-reflection happens throughout the study and is recorded and analysed as part of the overall research process (Finlay and Gough, 2003).</p> <p>This approach is not a search for any one “truth” about effective OT, but to bring an explication to what it is, within this particular study, which may resonate with others. Should participants use art, or metaphor to help describe their experience, it is envisaged that a metaphorical explication of the phenomenon of the lived experience of effective occupational therapy in CYPS will be proffered, with reference to original source material.</p>

	The results will be contextualised within the debate around the use of outcome measures, to see if currently available outcome measures are capturing the essence of what makes occupational therapy effective with children and young people.
How will I find out about the results?	Once the study has been completed and the data analysed (Summer 2016) the researcher will email a link to the general summary of the results on the NTW AHP Shared Drive.
What will happen to the information I have provided?	Your data will be stored safely, will remain confidential and will be destroyed after a given period of time, required under Northumbria Data Protection Guidelines (University, 2013-2014). The data may be shared amongst different researchers only for the purpose of research but in all cases confidentiality will be ensured.
How will the results be disseminated?	The dissemination strategy is to publish the study in peer reviewed journals or may be presented at conferences, within the fields of: mental health and learning disability, the profession of occupational therapy, and within the phenomenological research community. Consideration will be given to the best methods to inform children and young people of the findings. Be assured that however the findings are shared, the data will be generalized, and that your data/personal information will not be identifiable.
Have I been deceived in any way during the project?	No, there has been no intention to deceive you, indeed the methodology was chosen for its openness and transparency.
If I change my mind and wish to withdraw the information I have provided, how do I do this?	<p>Yes, you can withdraw any time up to the submission of the thesis.</p> <p>The research you will take part in will be most valuable if few people withdraw from it, so please discuss any concerns you might have with the investigators. Be assured that as all data are anonymised, your individual data will not be identifiable in any way.</p> <p>During the study itself, if you do decide that you do not wish to take any further part then please inform one of the research team as soon as possible, and they will facilitate your withdrawal and discuss with you how you would like your data to be treated in the future.</p>
Complaints	If you have any concerns or worries concerning the way in which this research has been conducted please contact:

	<ul style="list-style-type: none"> • Maria Quinn (Email: Maria.Quinn@northumbria.ac.uk) OR • xxx (email: xxx@northumbria.ac.uk) <p>To register a complaint:</p> <ul style="list-style-type: none"> • xxx (email: su.mcanelly@northumbria.ac.uk) <p>OR</p> <ul style="list-style-type: none"> • Dr Nick Neave, Head of Ethics, Faculty of Health and Life Sciences (Email: Nick.Neave@northumbria.ac.uk)
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FINLAY, L. 2011. *Phenomenology for therapists: researching the lived world*, Chichester, Wiley-Blackwell.

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Version MQ/2/DAS

23/9/2014

Appendix 6: Interview Question Schedule

Project Title	<i>“Occupational therapists: Their Lived Experience of Effective Occupational Therapy with Children & Young People”</i>
Principal Investigator	Maria Quinn (Email: Maria.Quinn@northumbria.ac.uk)
Supervisor	Dr xxx (Email: xxx@northumbria.ac.uk)
Equipment	<ul style="list-style-type: none"> • Room, table, chairs, do not disturb sign • Digital recording device • Microphones • Clock • A4 pad and pen • Reflexive Journal • A4/A3 – Drawing paper, art materials • Question schedule • Water & glasses
INTRODUCTION OPENING	<ul style="list-style-type: none"> • Welcome and thank you for coming.
	<ul style="list-style-type: none"> • This study will focus on giving voice to the experience of occupational therapists, to explicate the lived experience of the phenomenon of “effective occupational therapy with Children and Young People”. • The main aim today is to hear about your experience of effective occupational therapy with children and young people. • You don’t need to analyse it, just describe your experience of it, there are no wrong answers
	<ul style="list-style-type: none"> • Your contribution is important, because at the moment the voice of CYPS OTs is silent in the literature, • We are hoping this study will give some insights into the world of CYPS OT and understanding effectiveness from the therapists’ point of view.
	<ul style="list-style-type: none"> • I am hoping to interview each person just once, so the sessions allow for plenty of time to hear your views - today will be no more than 45-90 minutes.

	<ul style="list-style-type: none"> Before we start I need to check that you understand about the study: <p>? Have you read the Participant Information Sheet?</p> <p>? Is there anything you would like me to explain, or to have more information on?</p>
	<ul style="list-style-type: none"> Once you are happy to proceed, you need to read and sign the Informed Consent form. <p>? Can you read through and answer the questions and if you are happy to proceed, please sign the form....</p> <ul style="list-style-type: none"> I need to sign the form too.... The form will be scanned and kept securely as part of the electronic records of this study.
	<ul style="list-style-type: none"> If at any stage you would like to withdraw from the study, please let me or my supervisor know, I will give you details about that at the end of our discussion. If you don't want to answer a certain question that I ask – just let me know, that's not a problem at all. I am keen to hear your views, the way you feel comfortable to share them with me.
	<ul style="list-style-type: none"> We will start the interview shortly; do let me know if you need a comfort break.
	<ul style="list-style-type: none"> The interview will be recorded and a transcript taken of what is said, I may take a few notes too. I will just turn the equipment on now to so we can get started. Interview 1 – at location X, between MQ and X, date & time X:
BODY	
Phase 1	<p>? Can you think of any situations when you experienced “effective occupational therapy with CYP”?</p> <ul style="list-style-type: none"> If so, think of 1 or 2 which stand out as being good examples, where there were moments of breakthrough. <p>? Please could you describe, in as much concrete detail as possible, your experience of effective occupational therapy with children and young people?</p> <p>(“concrete details” – see possible prompting questions below)</p>
	<p>The following questions are an aide memoire; primarily we want the conversation to flow fluidly and spontaneously, with empathic openness.</p>

Prompting Questions, if needed	Environment <ul style="list-style-type: none"> • <i>Where did “effective occupational therapy with children and young people?” – happen?</i> • <i>Please describe your surroundings, where are you?</i> • <i>Who is around you</i> • <i>What do you notice particularly about this environment?</i>
	Behaviour <ul style="list-style-type: none"> • <i>Thinking of that time, what is actually happening?</i> • <i>What are you doing? Think about your movements, actions and thoughts.</i> • <i>How does your behaviour fit into the environment?</i>
	Capability/Skills <ul style="list-style-type: none"> • <i>What particular skills or capabilities were you using?</i> • <i>What communication and relational skills were you using?</i> • <i>What particular processes or techniques were you using when effective OT happened?</i>
	Beliefs and Values <ul style="list-style-type: none"> • <i>What beliefs of yours, guided your actions, when effective occupational therapy with children and young people happened?</i> • <i>What did you value most about effective occupational therapy with children and young people?</i> • <i>What was most important to you at that point?</i>
	Identity <ul style="list-style-type: none"> • <i>Did experiencing “effective occupational therapy with children and young people”, impact on your identity?</i> • <i>What sort of an occupational therapist were you, when effective Occ Therapy happened?</i> • <i>Did your identity impact on the experience of “effective occupational therapy with CYP”?</i>
	Connection <ul style="list-style-type: none"> • <i>Did the experience of “effective occupational therapy with CYP”, effect your connection to others (the community/the world)</i>

Phase 2 Basic Clean Questions	<ul style="list-style-type: none"> • I am going to ask a few prompts called “clean questions”, to see if your experience can be described in a creative way – like a metaphor, a poem or a picture. • There are some art materials here if you want to use them, or you can just answer the questions and see if it prompts you to use another way to describe “effective OT with children”. • Sometimes people prefer to stand up for this, to see if the experience you have described is something they can feel in their body. • You can do whatever feels most helpful, for you to be creative and feel comfortable
Attribute	<ul style="list-style-type: none"> • So, “effective... occupational therapy ...with children ...and young people” <p><i>? Is there anything else about “effective... occupational therapy ...with children ...and young people”?</i></p> <p><i>? What kind of “Effective.... Occupational...Therapy...with children... and young people”... is that?</i></p> <p><i>? Has it got a size or shape? Has it got a colour... or texture... or sound ...or smell....?</i></p>
Eliciting a metaphor	<p><i>? “Effective OT with CYP”...That’s Like what?</i></p>
Location	<p><i>?Whereabouts....is “effective OT with CYP”?</i></p> <p><i>? Where... is “effective OT with CYP”?</i></p>
Sequence Back	<p><i>? What comes just before “Effective Occupational..T with C.. and YP”?</i></p> <p><i>? Where does: ““Effective OT with CYP” come from?</i></p>
Sequence Forward	<p><i>? What happens next?</i></p> <p><i>? Then what happens?</i></p>

Summarise	<ul style="list-style-type: none"> Effective OT with CYPS – that like.... X, <p><i>? is there anything else about Effective OT?</i></p>
	<ul style="list-style-type: none"> That's the end of those prompt questions. We are nearly at the end of this session <p><i>? Would you like to take some time to write about or draw what you described?</i></p> <p><i>? Is there anything else I need to know (or should have asked), in order to help you to fully describe your experience of effective OT with CYP? Anything you missed or didn't emphasise enough?</i></p>
CLOSING	<ul style="list-style-type: none"> Thank you. That's the end of the interview. We have spoken about your experience of effective OT with children and young people. I will turn of the digital recorder now..... If there is anything I need to clarify once the transcript is done, do you mind if I ring you for clarification? There is an outside possibility that we may need to meet again, for clarification – that could be any time over the next 6 months – is that alright? I have here a Debrief Sheet for you – it gives you a bit more information behind why we are doing this study and some practical information for your benefit. <p><i>? Would you like me to go through this with you now?</i></p> <ul style="list-style-type: none"> Do ring me if you need any clarifications. The results section of the final thesis will be put in the CYP AHP shared drive for you to access, if you wish to – that will be in Summer 2016, if you want I can send you an email with the link? Thanks again for your time; I am very grateful that you have shared your experience.

Version MQ/1/IQS

Appendix 7: Ethics Approval Letter



Professor Kathleen McCourt, CBE FRCN
Executive Dean

This matter is being dealt with by:

Professor Olivier Sparagano
Associate Dean
Faculty of Health & Life Sciences
Northumberland Building
Newcastle upon Tyne
NE1 8ST

1 July 2014

Dear Maria

Faculty of Health and Life Sciences Research Ethics Review Panel

Title: "Occupational therapists: Their Lived Experience of Effective Occupational Therapy with Children & Young People"

Following resubmission of the above proposal, I am pleased to inform you that University approval has been granted on the basis of this resubmitted proposal and subject to compliance with the University policies on ethics and consent and any other policies applicable to your individual research. You should also have recent Disclosure & Barring Service (DBS) and occupational health clearance if your research involves working with children and/or vulnerable adults.

The University's Policies and Procedures are available from the following web link:
<https://www.northumbria.ac.uk/static/5007/research/reghandbook.pdf>

All researchers must also notify this office of the following:

- Commencement of the study;
- Actual completion date of the study;
- Any significant changes to the study design;
- Any incidents which have an adverse effect on participants, researchers or study outcomes;
- Any suspension or abandonment of the study;
- All funding, awards and grants pertaining to this study, whether commercial or non-commercial;
- All publications and/or conference presentations of the findings of the study.

We wish you well in your research endeavours.

Yours sincerely

Jim Clark
Chair, Faculty Research Ethics Review Panel

Vice-Chancellor and Chief Executive
Professor Andrew Wathey

Northumbria University is the trading name of the University of Northumbria at Newcastle

Appendix 8: Informed Consent Form

Informed Consent Form

Project Title: Occupational therapists: Their Lived Experience of Effective Occupational Therapy with Children & Young People

Principal Investigator: Maria Quinn

Please tick where applicable

	YES	NO
I have carefully read and understood the Participant Information Sheet.		
I have had an opportunity to ask questions and discuss this study and I have received satisfactory answers.		
I understand I am free to withdraw from the study at any time, without having to give a reason for withdrawing, and without prejudice.		
I agree to take part in this study.		
I agree to be interviewed.		
I agree for the interview to be recorded and later transcribed into text form.		

Signature of participant..... Date.....

(NAME IN BLOCK LETTERS).....

Signature of researcher..... Date.....

(NAME IN BLOCK LETTERS).....MARIA QUINN.....

Appendix 9: Thematic Quotes

Quote	Quotes from Participants (Original source material available on request)
1	Antoinette: “she is somebody who self harms as well, so her ways of behaving is quite hard... to unpick it all. We get used to, quite a lot, to do the unpicking”
2	Cath described “uncovering” the cause: “The lead up... was all about the child's behaviour, as it often is. Then when you... uncover the many layers, because the behaviour is there as an example, is the communication that the child is not coping very well. We discovered that it was about relationships and the child wasn't coping very well with that”.
3	Bern: “...respect I think. And seeing somebody as a person, not just as a diagnosis, and being somebody, not just thinking about what's happened in the past. Obviously we have to be aware, but just seeing them as they seem to us and with all the potential that they have.”
4	Bernie “..a young guy who was very autistic ... he's had a lot of difficulties with the staff team and again, in terms of communication, I think there was a lot of problems and I think the staff team (not) understanding the level of structure that he needed, the direction that he needed, and how his interactions were... They interpreted him as being rude and non-engaging a lot of the time, when actually he didn't have the ability to communicate. But ...he enjoyed cooking and he could cook ... we maintained the sessions... not because he needed skill development but because he got a lot out of just being able to come to and engage in the session, he wasn't judged, he didn't feel like people were, I suppose, examining every little thing he did, he felt he was quite scrutinised I think...”
5	As exemplified by Faith: “We've taken what interested them and starting from the beginning they were able to introduce their own music into this session”.
6	Emily's example captured what child-centeredness means to the child: “I showed him into ... the kitchen and ...his face lit up...it was like he owned the space a bit. So he started, he was obviously familiar with the kitchen environment and he got really excited about what he could make...something really special for himself.”
7	Chris described it as:

	<p>"There is an understanding of what the motivation towards occupations are, therefore you can plan your individual sessions based on ...what makes them tick and what motivates them to get out of bed, what makes them want to work. What's their own goal, what satisfies them, a bit of the COPM model?"</p>
8	<p>Emily</p> <p>"I think children need to be accepted for who they are, they need to be made to feel safe, they need to be able to say what they want to say to you without you being shocked or saying it is wrong or to judge them in any way. They need to be able to express themselves, even if it's negative things like anger or distress, in a way that feels safe."</p>
9	<p>Cath: "...trying to help him reflect and empower and help him, as an expert in himself. I always go back to that. You know it's...expressed through the MOHO stuff, where the client is the expert and I asked him once. 'Do you know who the expert is in this room' and he said 'well you are' and I said 'well how can I be? I'm not in your body and not in your (life), you know I said you are the expert... in you'. And he said 'no one's ever said that to me before that I'm an expert in anything!'"</p>
10	<p>Cath detailed what engagement actually looks like:</p> <p>"...I kept keep going back and she knew that it wasn't that I was forcing her to engage in sessions but it was taking that very much non-judgemental approach, just to hear, I would like to spend time with you. I like to get to know you and to find out about what she was actually interested in and what was important to her."</p> <p>Within this, Chris highlighted the importance of rapport:</p> <p>"Sitting down with the young person, getting to know them and developing that rapport and making sure that relationship was developed first ...finding out what ticked ...just getting to know that young person and allowing them to fit in and be comfortable."</p> <p>Also, Cath aimed to get on their level, physically and emotionally:</p> <p>"Yes and that therapeutic relationship was key ... when you work with kids, get onto their level not just with the play but with the emotions and that therapeutic friendship, if you like. So, he had to trust me a lot".</p>
11	<p>And finally, Antoinette described the importance of the relationship:</p> <p>"I suppose in lots of ways I do think a lot of it has been about the actual relationship that I have been able to develop with people"</p>
12	<p>Emily "That's what I said at the beginning of all of our sessions ... within the sessions really, you can pretty much engage in whatever activity you want, ... They are the only rules that are around safety, you keep safe, I have to keep safe, the equipment safe and obviously something about safeguarding and that sort of thing confidentiality definitely."</p>

13	<p>Faith “I think that fundamental power at the beginning and the luxury of time, giving her the chance to lead, and be able to do, herself and be able to tell me what to do and how she wanted to do it.</p> <p>... it's about you facilitating that person to be a leader and actually have that sense of control...and actually saying. Well, we've got a room, what are you going to do? ... like the play therapy approach, allowing the young person to explore their own environment and me follow them.</p> <p>... I would actually copy what that what they were doing... I think that's in the early stages that really helped with that therapeutic relationship, about trust and building a rapport. And this person can't communicate very well but can do. And can function quite well in the doing, but can't actually articulate themselves.”</p>
14	<p>Antionette “So I stuck to my word, it is all about that trust and being consistent.., not expecting too much and being able to understand where she was coming from. I mean it wasn't just about tolerating it, it was about actively being warm, being there and offering to talk if she wanted to”</p>
15	<p>Bernie “it's the therapists approach, the communication style... I think it is not easy for a lot of the young people because communication is huge, especially around the learning disability ward, is not what is being said, it's how it's being said - that has a big impact...</p> <p>I think the keeping quite calm, the allowing the silences that they don't always have to be filled. I mean, I'm not great at it, but just trying to simplify language... to clarify, and just listening to what's being said and just using other mediums If verbal communication isn't working. Getting a pen and paper out or paints out or using an activity to help aid that communication, which I think, the staff on the ward staff don't always have the opportunity to do, as we do.”</p>
16	<p>Cath “I think it is the willingness and the ability to change track, to be a container and then being an enabler and ... where you can say to the child ‘how are things going’. So there's a flexible approach to how you work. And where you work ...everything is for the benefit of the child... yes, to be creative and to be solution focused.”</p>
17	<p>Chris: “I made an effort and I persisted and I didn't give in, so it culminated in him feeling confident and able to talk to me.”</p> <p>Emily: “(She) pushed the boundaries...so there was lots of concerns about this really troubled lovely little girl, that was quite difficult to manage. I persevered and persevered and I used to see her every week and I saw her a very long, long time ... Sometimes. It can be frustrating.”</p> <p>MQ: “and do you ever give up?”</p>

	Emily: "Never, ever, ever. I don't think I can ever remember a time of giving up. I felt like it".
18	Emily <p>"...people (CYP) want to know all about you and ask you loads of personal questions. I find staff have different boundaries around that and I think that's the bit I find frustrating ...I struggle with other members of the team they don't have the similar boundaries. A young person could tell me where someone's been on holiday, which car is theirs in the car park... I wouldn't divulge any of that if a child asked me loads personal questions I'd be thinking...Why are they asking?...There's a reason why they are asking you and you need to reflect it back to them or wonder (why)."</p>
19	Bernie "she was going out with ward staff at the weekends; they sort of took on board the care plan that we had been working on and started using public transport, to let her experience that...They felt more comfortable with this case; we knew there was a discharge plan. .. We knew what we were working towards, so everyone was on the same page. She was someone that we knew we would be doing a lot of rehabilitation with, which I thinks it sit very nicely with OT."
20	Antoinette: "I do think the doctors do value OT and what we do, I think it is valued by the nurses but I do think there's something about us being able to bring back a real picture. ... I think there's some real recognition that, in the real world, whereas the medication and their conditions are part of it, how people actually to do things, I do think that's really recognised.that people really want that."
21	Antioette "She came in with query psychosis; I mean I think for the first couple of weeks we were absolutely clear that she did have psychosis. To be honest the first I ever met with her though, I felt quite sceptical about the psychosis, although she is still being treated for that."
22	As illustrated by Bernadette: <p>"some weeks she would engage and others she wouldn't, but I kept going back every week so that she knew I wasn't going to go away, not in a bad way, but that I was always going to offer sessions whether she engaged or not."</p>
23	Antionette: "Initially she would always be quite scowly ... a lot of people would turn away and take that as not interested, ...after a little while her guard would come down... actually she was very vulnerable really. So, after a little while, it was obvious that she enjoyed it, she was warm and she would smile and be open in her conversation. I think it was just a lot of just "slowly slowly" and just sticking to the sessions with her, and also allowing her away from the confines of the ward ...There was just layers and layers and layers

	of just barriers that she, I suppose held her back from a being able to participate really. ...someone isn't going to build a trust with you overnight".
24	Grace: "I ended up seeing him on a weekly basis for far longer than I should have done... for the service specification. We were only supposed to do six week blocks. Week-on-week I could really see that it was working for him, he was building skills and mum was going back and doing activities with him as well. ...and actually see the progress from week to week, a little bit more. (It was) closer to 18 weeks. Because he was ... just starting school, he was in reception going into year one, and in that transition moving on from playing and actually having to sit at a table and doing a bit more of the work. I felt it was a really important time to try and get in there and do some work that was going to be really effective for him. And, by the...halfway of 18 weeks, he was able to hold a pencil which was a massive, massive thing for him and his mum ... He was a lot more motivated to do it and they saw the change like that in school as well."
25	Diane: "(It's) the amount of time it can take to engage children who are extremely troubled... I feel that... isn't available as much now for therapists. ... I feel that now my work is lacking quite considerably because I don't have the quality of time that I used to have to spend with children ... research around play and how children use play and how children use the therapeutic relationship has highlighted that ... it's a process that's should never be hurried and is a gradual process that takes time to evolve and it has to be very much at the child pace... It shouldn't be hurried along and can actually take substantial amount of time before...(they) gain some understanding of what's happening to them."
26	Faith: "I think that fundamental power at the beginning and the luxury of time, giving her the chance to lead, and be able to do, herself and be able to tell me what to do and how she wanted to do it. I think that was really, really a good learning experience for myself because the pressures of everyday we tend to rush things, you probably do we probably push a little bit too quick, when somebody is not quite ready.... She has actually developed a lot more skills and she's functioning."
27	Faith: "...When things are getting too stressful. You keep that clinical session. Always make sure... I have to switch my head in 'I'm going into a clinical session. Let's leave everything outside and out of the room'. I think it's about being caring and compassionate, and visible, being consistent, listen to their needs being approachable...there are some things that help you with the engagement, process."
28	Bernie: "I feel like a lot of my role is giving them that timeout ... I'm not asking them lots of direct questions and so actually we do cooking fairly regularly and I seem to get - she offers up a lot more information about what she's thinking and feeling and how she's found the last week. So that's been really positive."

29	<p>"I noticed that he had tried to disengage from the activities ... I decided to work more with the carer and asked psychotherapy to do some more work with the boy...because he had started to talk and I had enabled that talking and I wanted psychotherapy to just have a look now ... I thought this was a good transitional time for him to start to work through some of that stuff in readiness for the future."</p>
30	<p>Faith: "I think without being too pessimistic, I think she could be in services for a very long time before we can get her to a place and she's ready. There is some hope that she would get in-depth interventions and we can pass those skills onto the OT, in the MDT. ... But then we have all those other demands out there where we are commissioned to provide certain services in a certain period of time".</p>
31	<p>"We made a card, written down with the exercises he wanted to do and what weights he could safely do. That was really good. That ended everything we had done. It was the culmination of his OT. And in school he went to a big secondary school during this time, and the worry was how he would deal with that transition. He did really well actually". Cath</p>
32	<p>Antoinette: "she was under the duvet. When I went in and so I says hello. She put a head out and came out ... She sat on the bed ...And I said I hear you been doing your puppet,... you might want to do a bit more. She said that she would but could we just sit in her room. I said ..could we possibly sit on the windowsill just outsideShe did come out and sat on the windowsill outside... something needed to be glued on and I asked could we go to the art room to do that because the art room is just around the corner. And we did. I think she needed to be able to sit there and be together for a bit before she could go around there. She wouldn't have gone straight to the art room, from her bedroom..."</p>
33	<p>Bernadette: "We are limited to space that we have, but we do have a small OT room that we've been able to protect. It's bright it's got a nice big window it lets light in. The windows on the ward are all darkly tinted glass that people can't see in, makes it feel that bit darker inside, so the OT room is a nice light room, you can have a window you can see the trees. You can watch people walking the dogs. We have a lot of conversations about that, just sort of noticing the outside world and what there is out there ... what's going on. ... just the light makes the difference."</p>
34	<p>Diane: "It's about having basic respect of children and sometimes it's easy for professionals to almost not see the child and see the system around the child. You know, communicate with their parents rather than the child, answer the telephone, if it rings in the middle of appointment with a child..."</p>

	<p>"I am working with a young girl ... who has withdrawn consent for the information to be shared and has a legal right to do so ...I do believe that tied in with basic respect comes a child's need for a degree of confidentiality in order to be able to grow and develop, and get the most out of life, but obviously are clearly in line with safeguarding procedures...</p> <p>I've worked with quite a few children over years to have been extremely traumatised and extremely troubled and can't move forwards at all. You (and they) know they need that space, you also know that if they do really talk to you about what's happening for them (make a disclosure), everything else around them falls apart. ...You can counsel them, you can talk about that, but in that child's mind they are not ready to make that disclosure because of the implications that it would have on their whole system, and as a professional if they did, you knew you couldn't keep that confidential, you have to instigate safeguarding proceedings and it is essential".</p> <p>Diane commented on OT skills which enabled the young person to make progress despite the system restricting them:</p> <p>"Again that's another quality of OT is that we can be extremely resourceful in how we use the environment and the activities and actually we did work in a way which felt safe. We managed to work on the feelings but actually we would have done better if we had actually worked on the facts as well, I still feel that we managed to make some emotional progress."</p>
35	<p>Grace talked of the antecedents to her OT session:</p> <p>"she hadn't had a restraint but she had been escorted from where she was. She bites and was kicking and she was being quite aggressive, so was escorted from her flat into a safe space, and probably only had about 10 min and was able to count down and go for straight from in there, into occupational therapy session. Yes she did cope really well. She did have that structure and I went in and said I had everything ready. I'll give you another few minutes and then you can come out."</p>
36	<p>"So that prompted me to move on, to what the parents perspective was of that and talking with the child in terms of confidentiality. He might say something and I would say well 'do you think mam knows about that?', Do you think I could talk to her about that?' So it was really about bridging those gaps that was the problem."</p>
37	<p>Chris "...there's more group work being expected like DBT and social skills, there is a greater kind of emphasis on that. ... that's good ... (but), it doesn't replace what's really necessary before the group work, which is the one-to-one individual work and ... that ... is what I need to hold onto for the young people's sake. ... that one-to-one prepares and plans and allows space to talk about a wealth of different issues and learn the wealth of need that makes the intervention in the group be more effective."</p>

38	<p>Chris: "Not only are we doing a graded programme with regards to increasing the distance and the stimuli when out, but using lots of visuals and using lots of strategies, so that we do a sensory assessment beforehand, so we've got a box of tools for him to use when he's out: sensory fiddles in there, headphones that he puts on and listens to music if the noise of being outside is too much. We've got some guidance, which helps to support him, so we lock the doors. He suggests to the driver when he's ready, he's got the music in place so we turn the engine only when he is ready and there are various things that he can do such as counting the colour of cars just writing 1, 2, 3 up to 100 of the number of cars he passes. We do a social story with him before we go out so he knows a little bit about the predictability."</p>
39	<p>Faith: "I think the positive risk-taking, being able to look at her level of functioning and being able to pull out what she can do... We can only pass on recommendations as much as we can. I would have liked to have seen her; I think the risk could be managed. I think the risks; the positive risk-taking would have helped."</p> <p>"Yes. Yes I think, our assessment of risk and the whole care planning is ...in terms of going out in using public transport that's the focus of my care plan .., yes we are aware of these risk factors but this is the preventative measures were going to put in place and this is the support which is in place, how we're going to grade it. The therapeutic reasoning as to why we are doing it, the goal for her was to become more independent, to develop more confidence. Their (nursing) care plan was to make sure there was an AWOL procedure, the history. It was all the kind of the formalities. It didn't seem to have much therapeutic value in it for me and I think that whole risk-taking, the initial reaction is to think about... What has, what could go wrong? I think we can have a quite a big influence in terms of activity and what they kind of get access to".</p>
40	<p>"...you can move quite freely and flexibly between looking at a motor skill that needs to be developed because that will help them achieve better at school, or you're looking at a social skill that will help them engage with his peers, which adolescence is all about...appearances and it, that becomes really their priority engaging in their peer group. And you're looking at developing his activities of daily living so that he feels more independent more confident about himself. And you giving loads of praise to help his self-esteem, you are giving skills to help his emotional literacy".</p> <p>"on the learning disabilities side, is all around the sensory processing approach, which is very key at the minute. But I think this seems to be a lot of our work with that ward at the minute".</p>
41	<p>Emily: "I would grade it in a way that we start off with less threatening things, and basic things, and develop. And those sessions are usually about...early on, about them telling me about what they know,</p>

	<p>but in a safe way and so we sometimes do maybe little games about what words they want to use for this body part...because people often get really embarrassed about using certain words or certain sexual things or body parts. So we do a bit light-hearted...so we have a bit of a laugh about it, so it's, it's not serious and it's okay, it's a bit of fun."</p>
42	<p>Bernadette: "Yes, yes and there were times she would come back to her OT sessions and tell me about stuff that she had done. All the things you set as short-term goals. When you're out on leave or the ward why don't you try doing this.... How about trying to do this all thinking about what could you do and her coming back and saying all "I went out with the staff" or "I went on the bus" which and we didn't just take the car. It's almost not quite homework but setting the goals but that fact that she's retained that information and followed it through, and thought it valuable enough to tell me afterwards. So she was able to put that link around what we were doing and she could do and how she took it forward and brings it back. She did come back into tell me sort of thing."</p>
43	<p>C: "It's enabling the system, which is environmental. It is almost like: someone comes out of hospital and they have to use a bath board and seat, sometimes you help the family to do that, to help the client, sometimes the client. Sometimes the condition gets better or worse. So you would just...Its sometimes better to talk to people about what you see, in terms of equipment, environmental adaptations. But what I am doing is I am changing the environment through psychoeducational adaptation." MQ: "So people are your bath boards?" C: "Yes. That's it." MQ: "Is there a metaphor...?"</p>
44	<p>Chris: "I was just thinking about the woven basket. Because it's OT and everyone refers to the woven baskets. For me, the explanation of demobilised soldiers with sore hands weaving a basket, you know that to me makes a lot of sense. I have a passion for what the soldiers did in the First World War. The young person is in the basket, is in the centre of kind of everything that we do and a basket kind of, is protective but it's also kind woven together in all its different strands of woven material, whether it be strong, weak or whatever. Altogether it makes it a strong component and it is all about containment. I think therapy is about containment. but it's also about ... the lid can come off the basket and allow the young people to grow bigger and express themselves where necessary. The lid can go back on top of the basket of containment is required for a while. It's all those woven strands of the multidisciplinary team and the young person's choices in life and I think all linked together to make that strong cocoon to allow someone to feel safe and allow them to do what they need to</p>

	<p>do within the basket in order to come out and be a bit more daring and dangerous and risky if necessary when the lids off.</p> <p>I think it would be the woven strands on the outside could be very colourful themselves and maybe from a distance it may all look like one colour, but when you come in closer it's all very separate and they each have their own unique colour. Woven baskets get splits in them, get little rips in them, but it's the other bits that hold it together when there's a hole in one component of what of the strand. You know, you can take that out and repair it and weave it back in and make it strong again. I guess that's what I am thinking. I guess the person who does the weaving you know could be a combination; I don't think anything can be produced by one person. Maybe, it's the young person on the inside doing the weaving from the inside and maybe it's the therapist that is doing the weaving with the multidisciplinary team on the outside and together they make one thing, which is that basket."</p>
45	<p>Faith: "I keep thinking of a rollercoaster, because that's how I feel about working with kids, is that when you actually connect with them and you can see the change, it's absolutely amazing. It's just, the best feeling ever, when you make that connection and you can see progress and development and you can see the children are kind of setting off down a path that is better for them, that they have chosen and they have had a part in. That's amazing. And that's the highlight but then the low bit is kind of really quite horrific in managing the kind of dynamics around working with children and the emotional processes, the risks, the legal system and around kids.</p> <p>The fact that we are working in, it needs to be said, were working in times where people aren't investing in children's services and it makes me so cross, that when we have all the, you know, developmental research, the risk and resilience theory about interventions with children at a young early age and the prognosis for children for children if we intervene early with families, you know, the research is there, risk and resilience theory, why aren't we investing in children? We pour money into adult mental health but it's too late. We actually should be pouring the money into children's services. Because actually if we get that right then we don't need it as much of the rest of it and it makes and that's the lows for me, having to compromise for what's right for kids when, actually, I'm in quite a protected service, when I hear my colleagues talk about life in the community, I still fail to understand how it's got to this. How we place so little value on child mental health. You know it's national it's in the press is not enough beds. There's not enough care, when actually you've got to invest in children's services in order to shape the development of our future population. I don't understand why it's not happening, that's the low.</p> <p>It's kind of keep on going and not like jumping ship in joining the millions of people in the private sector, that are carving out little businesses overcharging for a little bit of sensory intervention, when</p>

	actually, if you just put the money in and offered a holistic package of care for kids when they needed it most, that would help I think.”
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Appendix 10: Lifeworld Quotes: Project

Child Project	<p>Commitment to attend occupational therapy, as being important to her life:</p> <p>"We'd have a cuppa tea. Try and engage with quite a low-key chat about something and then I had a short period of time off work and when I came back I went back to see her to tell her I was back and I asked if she wanted sessions and she from then, in the past year, she has attended consistently for weekly, or twice-weekly sessions." Bernie</p>
Child Project	<p>"I think it's just in their own way...She's not interrupted. She can do it the way that she wants to do it and it's just predictable for her." Antionette</p>
Child Project	<p>"I think possibly they would possibly say that she was motivated to go (to OT). And to think, to be honest, it was her drive that made them happen, more than the ward staff" Antionette</p>
Child Project	<p>"We were concerned about with the school being off certainly over the summer. She asked me if I was going to be around over the summer so I think she was concerned about not having OT". Ant</p>
Child Project	<p>"actually this week she cooked something for tea, she usually cooks sweet recipes. So she cooked a curry for the tea, so that was a little bit different for her really. And that was interesting because we had to multitask, going from cooker to sink, change for that, react to altering the cooking. She said I don't have to do this for cakes and things! I suppose in a way it's fun. I don't know what it is but she really gets into it and enjoys it and its a challenge". Ant</p>
Child Project	<p>"So we started working and every session he asked to be in the kitchen and that was obviously the place he felt comfortable. Gradually, over the weeks, he started to open up whilst he was cooking, about things, memories that it brought back. ... doing the process of cooking but I think for him, he must make connections about other things, he was good at or maybe not so good at. As he got able to feel safe. So he talked quite a lot about school and about knowing people, but not really being anyone's friends and being on the periphery and all those sorts of things". Emily</p>
Child project	<p>We have developed a good relationship through that I think, through that and just that we've exposed her to certain things. Given her some responsibility that she's not been able to have previously, not..trying to think of a better way to say it, but not ramming it down</p>

	her throat, just come in to have a little bit of time. Look at what we've got, allowing her to use things like pens she's building a fantastic wooden model house she is able to produce " Bernie
Child project	"he had been out with the school transport before had become quite aggressive and one of the reasons for admissions was really a breakdown in the school placement because travelling to and from school the unpredictability of the environment hadn't worked. So really, to just identify what he wanted to do , which was to go back to school and to go back to live with mum and dad ". Chris
OT project	For Bernadette, the OT project appears to be about engaging young people : "Yes some weeks she would engage and others she wouldn't, but I kept going back every week so that she knew I wasn't going to go away, not in a bad way, but that I was always going to offer sessions whether she engaged or not".
OT project	Diana's project was to always adapt environments : ".. Understanding that a child might be chronologically at the age of 15 but emotionally functioning as a three or four-year-old so that child has the permission to use materials that that they will find helpful ... You have a range of activities on offer ."
OT project	For Emily imbuing the child with the sense of control is central to her project providing occupational therapy: "I begin by giving them a sense of having some control over the session. He was a little boy aware (that) control was taken away from him"
OT project	For Faith it is that consistency : "...it's about the therapeutic relationship and that consistency for some of those young people because a lot of them have got past history of attachment difficulties, cognitive difficulties ... It's about being, showing some empathy and caring, and that being consistent."
OT project	For Grace also spoke of consistency and it is using the child's play interests : "Having a consistent person that he was coming back to see. ... He was really motivated then to attend and I always made it quite play

	based. So, using his play and interests to try and develop his skills ... He didn't realise he was working."
OT project	"I see them as one unit because I could do what I wanted in the hour, but if I wasn't then explaining it to mum why I was doing something in a certain way or why we were using this piece of equipment, Or what the activity meant throwing things at target . It wasn't about the throwing it was the things behind it. So, I found that made quite a big difference, I guess getting parents on-board and getting them to set the goals for the child made quite a big difference. Because then they're actually motivated to do the stuff at home. Fitting into a busy lifestyle is quite hard work " Grace
OT Project	"you look at the balance of occupations role you can help support that young person to provide. That you look at kind of what their aims are around intervention and what they would like to have within their care plan. That you work with them to identify what their aims are, that you write the care plans together " Cath
OT Project	"Yes I think, our (OT) assessment of risk and the whole care planning is around in terms of that, I put care plan together in terms of going out in using public transport that the focus of my care plan is very much around, yes we are aware of these risk factors but this is the preventative measures were going to put in place and this is the support which is in place , how were going to grade it . The therapeutic reasoning as to why we are doing it the goal for her was to become more independent , to develop more confidence ." Bernie

Ward Project	"I really appreciate the staff on the ward, must find it really difficult, they have to deal with the crisis. They're firefighting the problem behaviours " Bernie
Ward Project	For ward staff here whose projects was to engage the young person in her daily living : "I mean it was a good example of a team approach, where the staff were asking for feedback and were actually using some of the strategies she had developed in our sessions in order to engage with her in her day-to-day living on the ward." Bernie
Ward Project	Here, Bernadette sees providing consistency on the ward to be difficult due to staff turnover and this impacting on the care provided: "you've got a very consistent approach going on (in OT) and wards are, well consistency is never the easiest thing to get, just because

	of staff turnover and how many staff you need to get and it's hard to get that consistency, i think that has a bearing on it."
Ward Project	"Yes but I've been there two and a bit years and she is one person that I been allowed to take out by myself and not have staff escorting." Bernie
Ward Project	"Yeah, I think for me it's the therapists approach , the communication style and you don't get that, sort of, if you've got four different support workers on someone's Obs (observations), throughout the day , there's still going be a slightly different way of approaching a certain situation." Bernie

Appendix 11: Lifeworld Quotes: Selfhood

Child Selfhood	Grace talks here about a 5 years old boys emerging sense of self: "Halfway through, once it he was able to do it. He was a lot more motivated to do it and they saw the change like that in school as well. So, he was going to school and choosing to sit to do the pre-writing skills. "
Child Selfhood	A teenager Grace worked with was described here as finding her voice in a more informal environment: "I've actually found that there was one girl who really struggles with answering questions about how she's thinking and feeling because she's quiet often asked in this situation when they sat at a table and I would find it were pretty hard. So actually we do cooking fairly regularly and I seem to get she offers up a lot more information about what she's thinking and feeling and how she's found the last week. So that's been really positive. "
Child Selfhood	Dianne spoke of creating a more open dialogue for this little boy to find his voice and express himself through play: "Di well, he would act out where scenes, where the figures were fighting and the little boy was on the roof, the little boy figure was on the roof, and the little boy jumped off the building and I just, you know talked about how, how worrying and frightened I was feeling for that little boy in the roof... and how I wondered you know, what the little boy on the roof was feeling like, and I wondered who the little boy in the roof was talking to and he was able to open up a little bit about it...We started to have a bit more of an open dialogue ... He started to then open up and do a lot more regressive play with the sand and the water".
Child Selfhood	Similarly, a troubled boy found his social identity in the family following his occupational therapy: "the whole family where at odds because of the child's behaviour and there were familial relationship difficulties. ... Then I went into the family home and we made a family meal. We were working on the very Maslow's baseline, and trusting the child to have a role. He was a teenager and was really cosseted; he wasn't really trusted to be a teenager very much because of his behaviour. And we did a series of meal planning, preparation the finale being I was invited to the family meal . It was a lovely, it was just lovely. Everyone was being polite and saying how lovely it all was and the kids face - and finally he had found something that he was good at and I think his identity was in the family and his role in the family was a bit better re-established. "
Child Selfhood	Bernadette describes an adolescent with more agency in occupational therapy and a sense of her own individualised presence:

	<p>"We've exposed her to certain things. Given her some responsibility that she's not been able to have previously, .. allowing her to use things like pens she's building a fantastic wooden model house she is able to produce...Using sandpaper and small pieces to build and actually it's just allowing her to experience that, has been really helpful and treating her as.. although she is in children's services, I think she is quite an immature adolescent .. she's been able to come and not feel judged. Just to have a cuppa tea, actually use a kettle which she doesn't get to use. She doesn't get to make a hot drink on the ward and just to be..."</p>
Child Selfhood	<p>Bernadette notes progress over time, defined by a young girls improved social skills and identity in making choices to communicate, give eye contact and knowing what she likes and wants to do – her agency:</p> <p>"MQ So she will be giving you eye contact and talking, a very different presentation from the beginning?</p> <p>Bernadette Yes and I encourage her.... give her choices, even if it's.....like she's doing a collage at the minute, she can choose what colours. does she want to use the pen? does she want to use the paintbrush? She will take time; it doesn't come automatically to her. But when given that time, she can come to her own decision, and that's something that in the past two months, we've really seen an improvement in. She's starting to become...and it's starting to come more readily to her that... yes I do like that and I do want to do that."</p> <p>This latter example showing the emerging dynamics between the Lifeworld fragments – Selfhood, temporality and Sociality.</p>
Child Selfhood	<p>Antionette raises an important point about providing a safe environment within which young people can test out their sense of agency, which is unlikely to happen in other places:</p> <p>"she's quite bossy to a degree in sessions and she's "can you do this, can you do that, can you do this and I have this, is not that she's angry. She just gets quite animated in the sessions, as you say you do this and I'll try that and I think it is just somewhere where she can adopt different ways of being really. I suppose, it feels like she can express herself, knowing that she's got the support there and it's predictable. In some ways you could think that for her is not necessarily going (to happen) that she can be accommodated in that way, in lots of environments that she might go to in the future is for example, school, college, and things like that."</p> <p>Highlights the interconnectivity of the life world fragments, where this girls practicing with elements of her Selfhood is facilitated by the occupational therapy environment i.e. Spatiality.</p>

OT Selfhood	<p>Being an advocate for the child was talked about by the majority of participants and is reflected in Emily's insights:</p> <p>"MQ (OT) is person centred?</p> <p>E Completely. I really struggle with standardised assessments which are about getting through the questions or getting through the tasks because I think you need to. But that's all you do, but you never really understand the person as a whole. There is an element of being flexible and really get to know the person and understanding the person. You know, we owe it to them; they moved away from the home for a period of time, sometimes for the first time ever away from home and we owe it to them to be respectful and try to get to know them a bit better so we can understand them and help them, recommend strategies. For other agencies, help, help the parents"</p>
OT Selfhood	<p>Diane who notes the difficulty for others (MDT) to understand warns OT not to expect such understanding:</p> <p>Di I don't think they do. ... but I feel that, unless you are an OT, it's impossible to really understand fully what you're doing. So I think OT's have a bit of a chip on their shoulder sometimes when they kind of expect people to see the brilliance in what they're doing all the time, because actually what you're doing does look relatively simple. So I am taking a child into a room and getting the Duplo out, and I have actually got the luxury of being with that child for half an hour and of course it is going to be a nice time with a child who do this, that and the other, and I think it's very hard to expect other professionals to fully see the skill in what you're doing there. I've always felt as OTs we really have a responsibility not to have a chip on our shoulder and that we should get out there and show people, you know, you're thinking, your clinical reasoning, and what you're doing but don't expect people to fully appreciate it, because they don't live it."</p> <p>An endorsement of the methodological approach taken in this study, to seek to illuminate the understanding of Occupational therapy through seeking the lived experience of Occupational therapists themselves, explaining what 'effective Occupational therapy' is, being almost beyond articulation by OTs in practice.</p>
OT Selfhood	<p>Emily offers an interesting example of the OTs Selfhood, their sense of agency conveyed in demonstrating they could manage a 12 year old boy with behavioural problems, which was an important and therapeutic message for him:</p> <p>"So OT for me, is about giving the children a different kind of an experience from .. other professionals , children blossom in different ways. So we took him over, just 2 of us, that was quite a big decision because we negotiated with the nurses that we could do the obs (observations), because he was on obs we were trained to observe him, that we were fully PMVA (prevention of violence and aggression) trained, so if there was an incident we could manage that.. he was known for his aggression..it was about keeping him</p>

	<p>safe, really. So, we were able to, I suppose, show him that he didn't need an entourage of nurses with him. That he can come with us and we felt safe to have him and that we were comfortable to manage anything that happened in therapy and I think that was really important throughout his therapy. I think he had this impression of himself as being something of a monster that nobody could manage, and even his own mum was saying that she couldn't manage and he was needing this huge team of nurses to look after him and so I think, to get the impression that he could be managed and he would be safe and that we were not worried about having him on our own was quite a powerful message for him."</p>
OT Selfhood	<p>Faith paradoxically describes how not being the expert requires a lot of intervention in itself and a core element of the Selfhood of the occupational therapist, the dynamic of not assuming a professional expert position (ref) being described by a number of participants and being in stark contrast to the paternalistic (ref), medicalised approach (ref) often described in health services:</p> <p>"I think, maybe that young people do get that experience that they think 'I will come to you because you're the expert' but actually we're not the experts, it is about how you relate that and give them that. It takes quite a lot of intervention to actually convincing a young person that actually were not the expert and "you can and actually must direct your own treatment plans and care".</p>
OT Selfhood	<p>Chris brings another dimension of the flexibility sought by the team for what they want of OT - unique, specialist or filling gaps: I think they (MDT) generally see occupational therapy as quite important. I .. get a difference of opinion as to whether people want you to be unique role: .. activities of daily living in self-care and exercise etc and then productivity and leisure and sport and I see some people who understand the role of OT and are quite rigid and expect you to fit into all those components and then I .. see other people who don't mind what you do as long as it kind of means the young person's needs are filled in the gaps within the provision that might already be there for people."</p>

Appendix 12: Lifeworld Quotes: Embodiment

Life World CYP Embodiment	<p>Antoinette highlighted an interesting dynamic of ward staff:</p> <p>“I think in lots of ways the ward staff don’t really tolerate young people expressing that distress, I think there is a fear about maybe what might happen if it all comes out, whether it’s about impacting on other young people who are there or actually about staff not knowing what to do with it when it comes out and kind of wanting to keep things neat...”</p>
CYP Embodiment	<p>Faith shared her experience of the team expectation of a young person and OT taking a different approach:</p> <p>“F yes there on the autism spectrum but also got a lot of post-traumatic stress. An inability to work cognitively with psychology has been a really big challenge and I think, is actually getting this young person to actually regulate within a couple of hours. It's being this person's had numerous PMVAs within a day and really serious assault on members of staff, so this is why they were asking me to come through to see if there was anything else that could be. They tried all the talking therapies and obviously they weren’t coming to any great conclusions and it was actually escalating behaviours. ... if communication is truly difficult lets just stop it! And she did communicate, and she did speak about some of the stuff that was going on in her day in a very matter-of-fact and I would just mirror whatever she was saying. So I would, she said I've got PE next I I would say, so you've got PE next, I wouldn't say that's good or bad.</p> <p>F then she would say that I really like this, but I don't like this, so were starting to get a bit more of the emotions from her because she really struggles with - what is happy, What is sad? There was a demand from the team to say we need to do some emotional work with her and I said I don't think she's actually ready for this. Actually, she needs that therapeutic engagement and build up a trusting relationship.”</p>
CYP Embodiment	<p>“At one point early on in February that little boy would have said that if I couldn't have that thing, nobody would have theirs, and smashed them all over, he would've lashed out or attacked staff, but he didn't, he verbalised his distress to me. He would say, he would articulate how upset he felt and how worried he felt that he was going to get wrong. I just laid my hand on his shoulder and I said, it's okay, It was an accident you not going to get wrong and just gave lots of reassurance, I can see your upset and it's okay to be upset and it was an awful thing that just happen and he held it together for ...not very long and then he just left the room”. Emily</p>
CYP Embodiment	

	<p>“he started talking about whether he would be allowed to take the plants home. So I was just thinking about transitional objects and how important it was for him to take something positive away from this unit that was still physically there at home, so we would have a physical connection”. Emily</p>
CYP Embodiment	<p>“I think when we were out, she didn’t particularly like me talking to say a shop assistant, in the shop. It wasn’t that apparent, she (shop assistant) looked at me and I realised.. and I thought you can’t do that. We only realised this when we were out that she would give the shop assistant really dirty looks. I didn’t realise until the shop assistant was backing off ..(A. laughing). I thought, you can’t do that” Antionette</p>
CYP Embodiment	<p>“She came in with query psychosis, I mean a thing for the first couple of weeks we were absolutely clear that she did have psychosis. To be honest the first I ever met with her though, I felt quite sceptical about the psychosis, although she is still being treated for that.” Antionette</p>
CYP Embodiment	<p>“so there was something about the brushing (hair) representing her not having to be the person in charge, being nurtured and looked after a little bit and those that love transference in our sessions about me being this perfect mum. She wanted to be my baby. This is the one I mentioned earlier she wants to be my baby. But the tightness was about her having a physical feeling of me with her at school all day, of Like having, she could feel me in a hair like holding her and making sure you know that you know you’re all right and physically there with you and again.” Emily</p>

OT Embodiment	<p>Cath enacted a parents presentation as she described their conversation:</p> <p>“And she had has a mental health problems herself. That was hard for her to talk about that. Dad was clearly was uncomfortable. She was the stoic, strong person.</p> <p>M Yes I can see it in your body</p> <p>C yes and nobody would know that looking at her, but seeing her talk and listen to her talking about her kind of cut through for me, where everyone was. She wasn’t this stoic strong person at all.</p>
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	<p>And I think we did a lot of the work with mum and dad, which was about relinquishing that and what could dad do, for him to be the strong stoic pursuing sometimes and from mum to relinquish that.</p> <p>M So in that environment. There was you then the Mum the dad. It was mainly talking.”</p> <p>Though clearly the talking was happening in an embodied way.</p>
	<p>it just feels like it's something really big and important, something you can grab a hold of, is like physically there. Grounded sense about it. Maybe it's something to do with, you now there's been some breakthroughs or understanding of what's happened and and it feels like you've made some kind of solid connection or sense of what is maybe that's why it's a solid shape. There's something quite grounded, some sort of evidence of what you think of what you feel. Don't know</p>

<p>Life World Ward & Researcher</p>	<p>Bernadette describes the gatekeeping function of ward staff to enable her to take young people off the unit, without other staff:</p> <p>“Yes but I've been there two and a bit years and she is one person that I been allowed to take out by myself and not have staff escorting.”</p> <p>The sense that ward staff were having to manage a ward full of challenging young people, compared to the individualised approach of the OT, highlighted different approaches to risk management and hence the level of bodily/environmental freedom experienced by the young person, and the OT.</p> <p>“Bernadette Yes. Yes I think, our assessment of risk and the whole care planning is around in terms of that positive risk taking... The therapeutic reasoning as to why we are doing it the goal for her was to become more independent, to develop more confidence. I think it's interesting enough that I had had a conversation with a member of ward staff prior to that around trying to make sure there was a care plan there. That their care plan was to make sure there was an AWOL procedure, the history. It was all the kind of the formalities and the kind of... It didn't seem to have much therapeutic value in it</p>
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	for me and I think that sort of whole risk-taking , the initial reaction is to think about.. what has, what could go wrong. ”
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Appendix 13: Lifeworld Quotes: Sociality

CYP Sociality	<p>"We've been able to introduce some things that can actually be used on the wards. That's what it's about. It's not about that isolation, is not about having that one session, it is about how she was going to transfer that. She is calm and she started to ask.. 'may ..can I have this light down on the ward' and I said 'of course'. So I stuck to my word is all about that trust and being consistent and brought it down and now the ward of invested in their own light".</p> <p>Faith</p>
CYP Sociality	<p>"in terms of her confidence and just her self, how she looked at herself, her self care. It was much more.. I think... Initially she had layers and layers of make-up on, but she was much more toned down, much more just comfortable with herself really. I think from in OT point of view, she just maybe learned to be more open and trusting in her relationship."</p> <p>"I think just the openness, and the not so worried about sharing things about herself, but I think also, learning about relationships and the fact that she wouldn't necessarily share things with everything with everybody, and having some boundaries about, not being suspicious of everybody but being....(MQ selective?) yes...She needs to be able to deal with adult and young people, relationships, and you can't just get what you want by being aggressive, can you?" Antoinette</p>
CYP Sociality	<p>Bernadette described progress in social ways here:</p> <p>"I suppose the time it's felt most effective to me has been when she is actually taken the finished product and shown it to somebody to get their feedback whereas, before she couldn't tolerate any feedback at all. Whereas she's actually beginning to seek that out and see say "look what I've made", inviting other people into the session."</p>
CYP Sociality	<p>"I think just being able ..to see her being able to open out and embrace.. sort of...working with other people . She went from being someone who wasn't being very assertive, although she was engaged but she was quite a quiet individual. She brought other people in and she knew what other people were doing. What doesn't happen very often is that she understood the roles of everybody in the team and again she invited people into that. I suppose one of the things I am thinking about is.. she kind of did a game that she did with psychology but she invited me into that session for me to see that as well.. she wanted other people to see that she was developing and that she was progressing</p> <p>MQ It feels similar to the first example about this connectedness. That somehow the success you can see is where people are starting to join things up.</p> <p>Bernadette Yes</p>

	<p>MQ Like drawing people in...I'm wondering if that is a good indicator when you come to thinkingthis really is working they're making connections here. Not just in their head but with people and all the support around them... wanting people to understand</p> <p>Bernadette Yes.</p> <p>MQ This is a lovely example; it makes me feel really energised.</p> <p>Bernadette Yes, it's one of those, did that really happen? and that could happen, and it was the right thing for her."</p>
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OT Sociality (with child)	<p>Cath shares a powerfully honest account of wanting to provide stability but not create dependence:</p> <p>"So, I've been with him through all of these changes and I've held onto him, Sometimes there hasn't been part of a therapeutic intervention, but it's been part of just "holding" whilst we get him settled for the next run of: carer, school , social worker ...</p> <p>MQ so you're helping to preserve all his placement were every years if he's at school or at home . You are trying to extend his stable times.</p> <p>C so it came at a time and I hadn't seen him for a while, and he was there and it sounds really good, I was going on holiday. He was doing normal things. So maybe this is the time where we might think about you might not have to come to see me anymore, and I thought that was a good thing. And he burst out crying and obviously no one expected it. Everyone kind of looked, bear in mind we have talked about dependency didn't we, about dependency with the previous kid. I'd.. and he said 'I don't know why I'm crying, but you're the person that I've known the longest in my life and I don't know what I would do if I lost you'. And I thought okay then we'll talk about this, as there were lots of people there. 'Let's talk about this another time but I'm not going anywhere yet'. And that was difficult because had I created a dependent, but I couldn't think of any other way I could have run with this case under the circumstances...</p> <p>MQ You know in terms of the team had people thought that you where the consistent thread through all these different changes. An important part of his stability.</p> <p>C because rejection was a really powerful component. He had been rejected from much of his life and what that meant to him, really."</p> <p>Cath went on to talk about her emotions:</p> <p>"C Christmas just gone was the second Christmas ever, with the same family, his has had a Christmas for more than once and how poignant that was for him. the children usually have their own little box which goes around with them. And he had some Christmas decorations that he had made in his (OT) sessions. And he's</p>
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	<p>asked is carer this time 'can he take his Christmas baubles out of his box and put them with the family box'. Wow, the carer cries when she talks about that me an' all! that's really lovely. So I really want to try and protect this placement as much as possible . So I work with her as well</p> <p>M in your OT role?</p> <p>C in my OT role.</p> <p>Occupational therapy sessions over years had clearly had a significant impact on the teenage boy and on the OT, in terms of how they related to each other. There is no doubt that these examples show enduring trusting relationships being formed between OT and child and vice versa.</p>
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OT Sociality (with others)	<p>Cath spoke of her family work and helping to re-empower the child and the parents:</p> <p>"MQ So did you feel like you have permission from the young chap to be able to say these are the kind of things that are difficult? So you are bringing that communication from him so to speak.</p> <p>C I couldn't allow for parents to say to the lad. "What did you say that for", he wasn't in the room but he knew I was going to bring those things up . So I said 'What things do you do with your son' and dad said there was not a lot, and then I'd say 'yes, I got that sense' it wasn't a blame and shame situation. Obviously...it was the realisation in a gentle considerate way</p> <p>C I guess one of the benefits of being a parent, working in with children, is that you can relate as a parent. And sometimes as a child, we've all been children. So you bring little vignettes to try and normalise things sometimes. That you're not the only ones that go through this. Sometimes a bit of humour, yes, just a little bit of myself without, without disregarding what they would expect to be someone who can help and hold this as the experts and people get uncomfortable talking about being the expert, and like having a non-expert approach. But I really do think, that if you are someone who needs help and support and it's been a big thing, referring and talking in that way, you do expect someone to be an expert.</p> <p>MQ so there's something about your approach that is trying to Take away from that "The therapist is expert" approach, but normalising it</p> <p>C yes, because the whole essence is to re-empower the family units for them, not to become reliant on an expert because actually they are the experts and they are all a family"</p>
OT Sociality (with others)	<p>Di spoke of the importance of the relations with her supervisor, to keep her safe and inspired, within her role as an OT with CYP:</p> <p>"Di well, I guess I get... I do look for emotional connections with the people that I work with and I can't really see myself as an OT if I don't connect emotionally with the young person. The downside is that of that is that, emm you have to be fully aware of how you're connecting, and you know, in an ideal world yes you</p>

	<p>would be fully contained and you would be able to see where your influence is there..., But the reality is that quite often, you get over entangled with children or childrens' families and you need somebody external to be able to say “hang on a minute. Why are you saying this and why are you feeling like that?” You know some of the cases that I've done as part of the xx specialist service; you know where you work, and again you know you connect with young people but you're not sure why...and you need to have some really good supervision to help. You know. It's usually in my case, it is to pull me out of cases because am wanting to work with them for too long. So normally...</p> <p>MQ what is excellent supervision for you, in order to provide excellent occupational therapy for you. When it's really what you need it to be.</p> <p>Di What is excellent supervision? you know the probably the best that I get is... I mean I'm lucky because I've got... my supervisor is somebody who I've worked with them many years, the who I trust implicitly with my cases, so that I can go and I can really be honest about how I'm feeling, what I'm doing and I just feel safe to do that. I am really really lucky that I've got that because that is somebody that I've worked with for so long and I feel so safe with. I have that. But I also value the monthly psychodynamic OT supervision sessions .. once a month. ..., it just kind it keeps me inspired by what I'm doing, and stops me feeling that I don't have the opportunity to think like that anymore. Sometimes in the daily grind of it, you can sometimes feel like you're missing out on what you're used to do and I can get that from some supervision and thinking about cases.”</p>
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Appendix 14: Lifeworld Quotes: Spatiality

<p>Child Spatiality</p>	<p>“the staff didn’t have the time on the ward to really go through that with her, to understand it. It was much more about getting the service things sorted and helping her to not be so rude to others, but without really unpicking why she was so rude.”</p> <p>And the need to challenge rules, in order to help and meet children, rather than expect them to come to the therapist:</p> <p>“To get outside of some of the rules and regulations of the ward. In a way, a lot of the ward, this particular ward. They are kind of fairly separate from the rest of the MDT and they like it to be nurse led. So even going into a patients room, going where the patient is and having a bit of a chat before (you go out), is taking a different step. There's a lot of staff that would keep you at the door.</p> <p>I feel like it's more important as the therapist to be able to go into the young person's environment and show them that in that environment, they can express themselves. I felt it was quite important to be able to go and, I suppose I would go in and get a patient. Meet them where they are”.</p>
<p>Child Spatiality</p>	<p>“MQ It sounds like you re grading the environment in terms of it not being overly stimulating (Yes) and then once you get to know him and that there might be a different room where there might be more colour and stuff?</p> <p>C Absolutely. I knew from reading the case notes that there was some autism there and certainly by the initial presentation of lists and not wanting to come out of the room and looking at the timetable as to what was now and what was next, kind of predictable and predictability. It was evident that he needed, something that was quieter environment. I didn't know if it was the best environment long-term but it appeared to be initially.”</p>
<p>OT Spatiality</p>	<p>“So I always get to eye level when I'm engaging with them. I try not to to just take a child into an unfamiliar environment and assess them...then again it's about setting up the environment so that it's secure for the child. So even when I'm going down to X unit and I'm only going to see the child for the first time and only 45 min I will still try and make my little space as welcoming and supportive as possible for the child. I'll remove things from the room that I feel are threatening and intimidating and I'll try and soften the environment and developmentally make it okay for the child.</p> <p>MQ can you say a little bit more about what softening the environment is?</p> <p>Di so I'll take out the medical equipment, I'll take out the pulse and blood pressure monitor the weighing scales, and I'll cover thing's, screen things off. Again it's unplugged the telephone.</p>

	<p>It's about having basic respect of children and sometimes it's easy for professionals to almost not see the child and see the system around the child. You know, communicate with their parents rather than the child, answer the telephone, if it rings in the middle of appointment with a child, it's about you know. We use a lot of the work of Monica Lanyado who did a lot of work about creating a safe clinical therapeutic not just the children but for anybody who has intervention and a lot of the principles are very, they seem so straightforward and common sense, but actually when you look at modern clinical practice a lot of it does get lost in the kind of need to meet targets and get children through waiting lists".</p> <p>Diane</p>
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<p>Ward Spatiality</p>	<p>Bernadette describes here a difference in risk taking approaches on the ward compared with OT, which impacts on the young person in occupational therapy:</p> <p>"Bernie: you know this person in particular her, it's quite difficult, but I think although she is able to do that within our session it is because it's been allowed from, almost from, the beginning and obviously I've had it agreed from the MDT and it's all been risk assessed that she can access those things. But on the ward, it's a very specific thing that many people don't have access to. Then is gradually introduced and something happens that will be then you get the step back.</p> <p>MQ Is that a global thing of having it and then if there is a risk it is withdrawn?</p> <p>Bernadette Yes, yes it's an issue for her on the ward. If people get sort of access to certain things. It's deemed as a sign of improvement and she's very much sensitive to that. So, so that happening would she be showing to staff that she wouldn't be doing that well and she shouldn't have access. She's ready to move on now and she's quite vocal. My recommendations are that when she does move on she needs a positive risk-taking approaching. Trying things at the beginning and taking positive risks. When you take things away from her. That is seen as very hard - to reduce them, at a general level</p> <p>MQ Would you say that's one of the main differences to what's happening in OT and what's happening on the ward was happening in OT in relation to risk-taking and risk aversion?</p> <p>Bernadette Yes"</p>
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Appendix 15: Lifeworld Quotes: Temporality

Child Temporality - Looking Back	<p>Bernadette describes this girl:</p> <p>"before she couldn't tolerate any feedback at all. Whereas she's actually beginning to seek that out and see say "look what I've made", inviting other people into the session."</p>
Child Temporality - Looking Back	<p>"the baby wasn't focusing right. He has sweaty palms. He wasn't feeding right and I had to take it really back to basics and help the system understand what this baby is missed out on in utero and what might he might have to do to replicate that.</p> <p>So it was to go back to being on his tummy, ... his back, ... it's not just about its physical development. Even babies develop self-esteem when they can hold their head up and they get all that praise and the eye contacts, the reaching for food and all of that is inbuilt within that self-esteem and personal competence, the expertness."</p> <p>"...child by his behaviour and presentation was clearly saying 'I'm not coping at this level. I need to go back to a place I can cope'. So that's what we did. That was great. That was great."</p>
Child Temporality - Looking Back	<p>Emily described a not uncommon biographical and family presentation coming into the unit:</p> <p>"I'm thinking about the effectiveness, I can think of a few examples. One of them is .. 12-year-old boy .., who had been really difficult to engage, lots of aggressive outbursts. The police had been involved. .. he was performing quite well at school but that the school got a point where they were talking about permanently excluding him. There were a lot of attacks on mum and he was being really aggressive and violent to mum. Grandma ended up taking him away from mum for weekends and things, to get mum respite but that just fed into mums sense of not being good enough parent, to be able to manage your own child. ...He made up for it by presenting this mask to the outside world about him being ..the best at everything. Educationally they all said it was it was quite a bright boy but I think he was really struggling underneath, but that's the story that he tells that he was the best, that he had loads of friends. Obviously when you get to know many starts to open up, that wasn't the case but that was certainly the bravado that we got initially."</p> <p>So we started working and every session he asked to be in the kitchen and that was obviously the place he felt comfortable. Gradually, over the weeks, he started to open up whilst he was cooking, about things, memories that it brought back"</p> <p>Which transformed into this biographical exploration by the 13 year old lad:</p> <p>"So it led on to some quiet adolescent conversations about who he hopes to be what kind Man he hopes to be. His levels of aggression is what that meant, and whether his dad was an</p>

	<p>aggressive man. I suppose that was some of the stories that he had about his dad where quiet biased from his mum's perspective...</p> <p>And finally to: "There was also something about his cooking, that was about him nurturing himself and feeding himself and looking after himself and he went on and he started doing things like he planted a garden and he started nurturing the plants and talking about them in his therapy sessions, about how the plants were growing stronger and it was at the same point that he was growing in his strength and getting his strength."</p>
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<p>Child Temporality - Looking Forward</p>	<p>Another young lady that Bernadette worked with came with a positive biography and pushed forward her own goals for the future:</p> <p>"She previously worked, had done a lot of work, around her learning disability in trying to help inform staff around her of what helps and what doesn't help and she quickly progressed as she was taking that ownership as well but I suppose one of them "yes moments" came when we started to do a lot more community-based stuff. Actually, allowing her to experience some of the responsibilities that all teenagers begin to go through, so being able to do work about going to the shops. It was identified that halfway through admission that she should be working towards supported living and to be in a community-based placement and that she go back to a home in the local area, supported by staff there.</p> <p>MQ That's really good isn't it. To go from from medium secure to that, is unusual is in it?</p> <p>Bernadette It does happen, but not all the time. There are occasions, I think because we had identified with her quite early on with there being no low secure units in xxx, that makes sense for her to stay with us a little bit longer but to do a good transition."</p> <p>"B So, that she was coming and saying... said as she wants to be involved in their own cooking and could you help me to practice that? (MQ Wow)</p> <p>Yes it doesn't happen very often. It was sort of looking at what her priorities were and a lot what her life would be like in the community and not in the hospital and working with the team on the ward and around that as to, not make that specific just to OT sessions that she was able to do that with other staff and build up that up so it became part of her routine</p> <p>MQ So she was going out with lots of different people?</p> <p>Bernadette Yes she was going out with ward staff at the weekends; they sort of took on board the care plan that we had been working on and started using public transport, to let her experience that. I think for me, the main times... it was actually her</p>
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	<p>involvement in it... she had the motivation to want to move on, but she was actively seeking the support and assistance. But also she had, and it's not very often this happens, it's her ability to say when staff wants to do things for her she would say "no! Let me do this myself"."</p> <p>A powerful example of a young person challenging a culture which could foster dependency and a sense of institutionalisation (ref, Su, p 363 causation and proliferation of environmental factors for ch behr.)</p>
Child Temporality - Looking Forward	<p>The example offered by Cath here, shows the importance of empowering young people in their biographical journey:</p> <p>"I did the work and we went to a local gym. I got him enrolled into a gym and we did some graded type stuff, some activities. He was another kid who I said 'you are the expert'. Do you know - he cried, he said 'It's that I've never been called an expert in my life'. You know, you get the sense that most of these kids are so disempowered by their experiences, this is in the (Looked After Children - LAC) system, (its important) to help them be the expert"</p>
Child Temporality - Looking Forward	<p>The concept of risk and resilience is introduced here by Cathy, in how she visualised the balance of risk and resilience change and the boy she was working with assess himself as doing much more (Participation? Ref):</p> <p>"MQ when was the moment you realise you were making a difference to him?</p> <p>C In the gym session, like he said "look at me Cathy, look what I can do" and I think someone else in the gym, another adult said you're doing really well "yes I've done really well, done it twice, I am doing so much more". I think it was feedback from the carers as well. The concerns were much less. He was more willing to do different things.</p> <p>MQ But you could see it on him, in his in the way that you did that posture of him was running on the treadmill, when he was doing that he was proud of himself</p> <p>Cathy Yes yes you can see in the image and that the resilience levels were starting to come up and the risks were coming down."</p>

Child Temporality Looking Forward	<p>Chris spoke about another boys wish for a better biographical future:</p> <p>“And he was keen to have a role and a job, so very successfully, we well, he had been out with the school transport before had become quite aggressive and one of the reasons for admissions was really a breakdown in the school placement because travelling to and from school the unpredictability of the environment hadn't worked.</p> <p>So really, to just identify what he wanted to do, which was to go back to school and to go back to live with mum and dad. So we were able to come up with, one of the things that supported the therapy, was a pathway very visual. So, explaining what we needed to do or potentially need to do, to kind of progress with regards to his development within the transport idea.</p> <p>But we progressed really from him going to become more comfortable and familiar with cars and transport and washing them, sitting in them, taking photographs of them. His autism fitted in very well with wanting to take pictures of the number plates and signage within the cars etc and to cut a long story short, we progress from going in a minibus with four staff just progressing now, to going very short journeys to longer journeys” Chris</p>

Occupational Therapist Temporality	<p>Cathy also described a boy who had a traumatic biography and a lasting effect on her:</p> <p>“Yes. Let me talk about my longest case. This is the case I picked up from a long time ago. From a therapeutic perspective. I've been in the team nearly 8 years.</p> <p>C but this boy had a really traumatic difficult early life, as they all do. Being around lots of foster carers because of his difficulties and, eventually, we've got him into a placement which is it good. It's a very good unconditional approach to things. More of an understanding of the communication, that behaviour is a communication. And about how the child makes us feel and then managing that better. He is the only child that I ever had to restrain in my career twice. And I still have a bite mark scar, on my hand. Yes I can remember it</p> <p>MQ you've actually got a scar</p> <p>C yes I have a little scar on my hand where he sunk his teeth into me.”</p> <p>And then his parting biography:</p> <p>“yes I guess the boy I have restrained the only boy, and then hearing him say “ I don't want you to leave me”, that is the realisation of, the effect of the work and the relationship” Cathy.</p>
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Occupational Therapist Temporality	<p>Chris spoke of her biography with a young man:</p> <p>“He came into our service and spent a long time in his bedroom actually and really didn't come out of that bedroom apart from occasional sessions with myself. The reason I kind of worked with him so intensely was because I had seen him, built up a rapport with them when he was in mainstream Ward. So when he came to the learning disability Ward, I had a kind of a sense of responsibility that I knew him over and above other people. ... His one goal in life was to open a bank account. so, for the duration of the admission he did not manage to open a bank account, but I was able to get him across from the ward to... and to sit in the library to have a chat, to go in the kitchen to have a chat, we actually went into the sports hall and played some sports which I think most people didn't believe ever happened because this is a young person who sat in that room.</p> <p>But I think that relationship, as I said right at the beginning, I made an effort and I persisted and I didn't give in, so it culminated in him feeling confident and able to talk to me.”</p>
Ward Temporality	<p>The biography for ward staff as firefighters was described by Antionette:</p> <p>“I think just, then not giving up on people. Not saying the other staff do at all, I think, it's that I, I really appreciate the staff on the ward, must find it really difficult, they have to deal with the crisis. They're firefighting the problem behaviours and I appreciate we are in a more fortunate position in the work that we do with the young people, in that you get to experience some of the more positive”.</p>
Ward Temporality	<p>Faith expresses her frustration at the biographical pattern of the ward team rushing at implementing a plan:</p> <p>“So we join together a bit of a plan of how we can bring it altogether, when there is a lot of crisis there is another level of violence and aggression that this young person displays and about how we bringing the planning part into that. so that we've drawn up a plan. It was a big group and I was very vocal in that, it's all about doing and bringing less demands on her, when they pulled it altogether, it was too much. I am struggling with leading with this. If this young person saw this plan and they're on a plan at the moment that is kind of working, but not great, we really need to introduce this new plan really slowly and not - they were talking about introducing it overnight and I was saying no.”</p>

Ward Temporality	<p>In contrast the ward team biography of being supportive and understanding was clear for Faith:</p> <p>“yes, I have come away to the team, they have been a great support, because it's a safe place to be able to say “what the chuff am I doing?” (laughing) How many times will I have to get card making materials? It's exhausting, it is absolutely exhausting. But you kind of have to go through all of those emotions, and it does feel very normal and, I have felt frustrated and i've felt annoyed. I felt, I just want to get this done, but I just had to stop and just say 'it's okay, it's all right'... I did probably bend the ear my team quite a lot”</p>
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Appendix 16: Lifeworld Summary

Project	The OTs project – their ability to carry out activities they are committed to - is clearly seen in providing occupational therapy to children and young people with mental health/learning disabilities. During the initial phase of occupational therapy, there is overwhelming evidence that they do everything possible to engage children with MH/LD issues. By being highly adaptable and flexible they convey a level of acceptance of the child for who they are whatever their behavioural presentation. Their approach is underpinned by beliefs in the importance of being consistent, respectful, caring, compassionate, fair and gentle.
Temporality	Temporality, as a core component of conveying their commitment and determination to engage and build a consistent, therapeutic and trusting relationship to convey their belief that the child can take the opportunity to develop their own self-hood. It enables the OT to offer regular and repeated sessions (often weekly one hour sessions) and make themselves available to the child whether they wish to engage or not. Stemming from the temporality fragment occupational therapist utilises environmental manipulation (spaciality) in order to provide a safe and meaningful space, within which the child can carry out activities which are meaningful to them. Crucial to this endeavour is this child centredness of the occupational therapy approach which shows an acceptance and validation of the child as their own expert and leader of their occupational therapy session.
Sociality	An core aspect of effective occupational therapy with CYP is developing a trusting, non-judgemental relationship (sociality), where the child is truly seen as an individual with unique needs, ways of expressing themselves and an expert in their own recovery. This can appear in contrast to a system or culture which can be depersonalising, or see the behaviour, often challenging and requiring management, rather than the child.
Spatiality	The manipulation of the environment (spatiality) in order to maximise the child's engagement within it, happens prior to the child being in it. OTs prepare and plan for the first/initial environmental contacts as an important part of the engagement and project skill development for the child. Successful engagement in the environment or shared space is the first step of OThpy. Manipulation of the environment to maximise opportunities for the child to take the initiative and be successful, is core to OT. Transfer of learning in OT to other environments, is used as a key outcome measure for OTs.
Embodiment	Occupational therapy with CYP is an entirely embodied experience (embodiment), therapist and child sharing the same space/activity. The only rules established at the outset of therapy establish child

	and therapist safety as paramount. This conveys the importance of keeping the CYP safe and that the therapist is in control of this aspect of the session. It creates a safe and holding environment within which the child can maximise their sense of control and agency.
Project	Core to OT sessions is positive therapeutic risk taking, aiming to extend the skills of the CYP, so they learn and develop mastery (project), their ability to carry out activities central to their life. This mastery directly feeds into their sense of agency and identity – i.e. their Self-hood. The child developing their self-hood is a key way in which OTs measure the progress of Occ Therapy.
Discourse	OTs utilise their expertise not to assume a professional expert or power position, preferring to ensure the child is the expert in their own care. As such they provide an alternative perspective/view of the child within the MDT and operate a non-medicalised view of health and wellbeing. Lifeworld discourse analysis identifies that OT use creative, empowering, goal orientated linguistics and deconstruction of cultural norms./stereotypes, challenging the systemic use of the language of the medical model of doctor or nurse as expert, deconstructing such concepts by seeing the child as expert.
Self-hood	It would appear that this facilitation of the child lead role is an attempt to provide an externalised representation of a higher endeavour, to create or strengthen the child's own internalised selfhood. The objective of this project is seen in the dynamic interplay between these Life World Fragments, where their goal or project appears to be to enable child to establish a sense of self-hood and often for the first time, as sense of their own agency.
Project/ Spatiality	The primary method of achieving this project of the OT is to enable the child to choose a meaningful project to them, which is housed within a carefully chosen and graded environmental space. Drawing on skills of assessing motivation and meaningfulness of activities, the occupational therapists seeks to facilitate the child to carry out an activity important to them, within that environment, which they are satisfied with.
Project Selfhood	Facilitation which enables the child to complete their chosen project, results in an emerging and burgeoning selfhood for the child. Part of the social identity of the child selfhood is tested and explored

	through sociality. The effect of 'effective occupational therapy' on the child sociality is that they in turn can develop communication skills both verbal and non-verbal and relationships within their own right and which they choose to make.
Embodied/ Spatiality	Central to the success of occupational therapy with children and young people is that this is an entirely embodied intervention. From its humble beginnings in children being encouraged to get out of bed, to having informal opportunities to meet, explore their dreams and hopes for the future and to be working together in a physical environment with variable levels of proximity and contact, sharing food and air and laughter and time, the journey together within occupational therapy for both occupational therapists and the child is often transformational as well as challenging, frustrating, emotional and physical.

Appendix 17: Doing and Occupational Imbalance - Quotes

Reference 1: Bernadette describes their OT space compared to the ward:

"We are limited to space that we have, but we do have a small OT room that we've been able to protect. It's bright it's got a nice big window it lets light in. The windows on the ward are all darkly tinted glass that people can't see in, makes it feel that bit darker inside, so the OT room is a nice light room, you can have a window you can see the trees. You can watch people walking the dogs. We have a lot of conversations about that, just sort of noticing the outside world and what there is out there.. what's going on. Yeah. She sort of enjoys that, she likes nature, I think she's sort of... just the light makes the difference."

Reference 2: Bernadette & Ward Environment

Bernadette offers a glimpse of ward life in some in-patient CYP units, with challenges for managing risk:

"I think the difficulty is around, and it is partly you know, we're not there, we're not staff on the ward that are getting punched and strangled on a regular basis and it's that risk-taking on the ward that is a much harder risk to sort of manage or for us to have as much impact on and change and that's something that was difficult about that young lad being kept in seclusion for a long time. It was a very difficult case."

Reference 3: Bernadette describes Different risk taking approaches between the ward and OT

There is a difference in risk taking approaches on the ward compared with OT, which impacts on the young person in occupational therapy:

"Bernie: you know this person in particular her, it's quite difficult, but I think although she is able to do that within our session it is because it's been allowed from, almost from, the beginning and obviously I've had it agreed from the MDT and it's all been risk assessed that she can access those things. But on the ward, it's a very specific thing that many people don't have"

access to. Then is gradually introduced and something happens that will be then you get the step back.

MQ Is that a global thing of having it and then if there is a risk it is withdrawn?

Bernadette Yes, yes it's an issue for her on the ward. If people get sort of access to certain things, it's deemed as a sign of improvement and she's very much sensitive to that. So, so that happening (seclusion) would she be showing to staff that she wouldn't be doing that well and she shouldn't have access. She's ready to move on now and she's quite vocal. My recommendations are that when she does move on she needs a positive risk-taking approach. Trying things at the beginning and taking positive risks. When you take things away from her that is seen as very hard - to reduce them, at a general level

Appendix 18: Being and Occupational Alienation

Nvivo Analysis 28 March 16 14 references coded, cross ref Quotes and Occupational Alienation 10/4/16

Reference 1: Faith:

"It's the relationship that you have with the young person first and foremost. If it's consistent and meaningful and your truthful and you keep your promises as well as is reasonable and there is a professionalism about that relationship then I think if you provide nothing else to that young person that is the most important thing that you can actually provide that the therapeutic use of self in a professional way, but, but that meaningful relationship."

Reference 2: Chris & Relationship/rapport

"Sitting down with the young person getting to know them and developing that rapport and making sure that of relationship was developed first was something that was successful that young person first finding out what ticked not kind of trying to sort of, look good by steaming in with providing loads of different kind of opportunities for therapy but just getting to know that young person and allowing them to fit in and be comfortable."

Reference 3: Chris and Persistence

"I had a kind of a sense of responsibility that I knew him over and above other people. So that sense of responsibility probably made my persistence, my determination, my sense of responsibility just helped me to kind of work harder with that individual. I had a sense that I needed to sort of be there for that person. So I think that the thing that that was most effective with him was really the persistence. It was kind of three or four times a day going to see him because he wouldn't come out of his room (MQ Its hard) and it was extremely hard, but it's made a difference."

Reference 4: Chris and proof of skills as evidence of effectiveness

“But the effectiveness (of OT) for me is the fact that he came to this unit thinking I can't have relationships with professionals, they have all broken down, it's not possible for me to have that. So whilst there is kind of that sense of responsibility am I saying in two weeks time I'm not coming any more. There is kind of that kind of its need to explain that, you can make and develop relationships with individuals and people you know you've proved that you can, but it's still a fact he still has those skills of relationships and sports nonetheless

Reference 5: Bernadette & Engagement:

“On reflection of it, I been trying to think about what has worked, what has been successful and one of the things I think is the fact that I did think is, I kept keep going back and she knew that it wasn't that I was forcing her to engage in sessions but it was taking that very much non-judgemental approach, just to hear, I would like to spend time with you. I like to get to know you and to find out about what she was actually interested in and what was important to her”

Reference 6: Emily & professional Boundaries

Working closely with young people in in-patient services brings other challenges and Emily spoke of her frustration with nursing ward staff and professional boundaries and missed opportunities to consider the motive behind personal questions, to help children deal with issues:

“The thing I struggle with, and I've always struggled with, is people want to know all about you and ask you loads of personal questions. I find staff have different boundaries around that and I think that's the bit I find frustrating as I think I'm fairly clear about boundaries but I struggle with other members of the team they don't have the similar boundaries. A young person could tell me where someone's been on holiday, which car is theirs in the car park, because the kitchen overlooks the car park, so they say which car belongs to which staff, how many kids they've got, where they live, not their address but you know, if they live in X (a nearby village) or in Town. I wouldn't divulge any of

that if a child of a child asked me loads personal questions I'd be thinking...Why are they asking? For him... Not that he ever particularly did it.

I could think of all the children who were quite preoccupied about me and 'did I have children?' and 'where did I live and did I want children?' One girl in particular was really preoccupied with that. I was more interested in why she needed to know that and where that was coming from. I worked with her for a really long time and she was able to acknowledge that it was the desire to become my little girl, that in therapy she had done a lot of splitting and occupational therapy had become a good breast, you know, idealised and perfect and I had become this perfect mother that could do no wrong. And the motivation for her was all around 'how can I be your child? How can I take you home and give me this perfect life that I can dream about and imagine?'. So I am much more, that taught me a lot about answering questions from kids and understanding, you know, they're not just being nosy. There's a reason why they are asking you and you need to reflect it back to them or wonder (why).

Reference 7: Cath on the tension between providing stability vs dependency:

MQ so you're helping to preserve all his placement were every years if he's at school or at home . You are trying to extend his stable times.

C so it came at a time and I hadn't seen him for a while, and he was there and it sounds really good, I was going on holiday. He was doing normal things. So maybe this is the time where we might think about you might not have to come to see me anymore, and I thought that was a good thing. And he burst out crying and obviously no one expected it. Everyone kind of looked, bear in mind we have talked about dependency, didn't we, about dependency with the previous kid. I'd.. and he said 'I don't know why I'm crying, but you're the person that I've known the longest in my life and I don't know what I would do if I lost you'. And I thought okay then we'll talk about this, as there were lots of people there. 'Let's talk about this another time but I'm not going anywhere yet'. And that was difficult because had I created a dependent, but I couldn't think of any other way I could have run with this case under the circumstances...

MQ You know in terms of the team had people thought that you where the consistent thread through all these different changes. An important part of his stability.

C because rejection was a really powerful component. He had been rejected from much of his life and what that meant to him, really."

Cath went on to talk about her emotions:

“C Christmas just gone was the second Christmas ever, with the same family, his has had a Christmas for more than once and how poignant that was for him. the children usually have their own little box which goes around with them. And he had some Christmas decorations that he had made in his sessions. And he’s asked his carer this time ‘can he take his Christmas baubles out of his box and put them with the family box’. Wow, the carer cries when she talks about that me an’ all! that’s really lovely. So I really want to try and protect this placement as much as possible . So I work with her as well

M in your OT role?

C in my OT role.

Occupational therapy sessions over years had clearly had a significant impact on the teenage boy and on the OT, in terms of how they related to each other.

The same OT gave an endearing aside about seeing this lad she was still working with after 8 years, in a waiting room, like she was proud of him becoming a man:

“MQ So you are not his OT any more, so to speak.

C No. But he knows where I am. I saw him in the waiting area last week and I said “how are you doing” and you know he’s got a little bit of moustache happening over his lip and his voice is really deep ...”

There is no doubt that these examples show enduring trusting relationships being formed between OT and child and vice versa.

Reference 8: Antionette and the tension between professional boundaries and child centredness

She said that she would but could we just sit in her room. I said to her in a way it would be best not to, but could we possibly sit on the windowsill just outside of it all is was just outside of it all. Her room was dark as well.

Sometimes it's hard isn't it because you don't want to not be patient centred and be, but also don't want to do things that aren't professional

Reference 9: Bernadette described their OT space:

"We are limited to space that we have, but we do have a small OT room that we've been able to protect. It's bright it's got a nice big window it lets light in. The windows on the ward are all darkly tinted glass that people can't see in, makes it feel that bit darker inside, so the OT room is a nice light room, you can have a window you can see the trees. You can watch people walking the dogs. We have a lot of conversations about that, just sort of noticing the outside world and what there is out there.. what's going on. Yeah. She sort of enjoys that, she likes nature, I think she's sort of... just the light makes the difference."

Reference 10: Bernadette offers a glimpse of ward life in some in-patient CYP units, with challenges for managing risk:

"I think the difficulty is around, and it is partly you know, we're not there, we're not staff on the ward that are getting punched and strangled on a regular basis and it's that risk-taking on the ward that is a much harder risk to sort of manage or for us to have as much impact on and change and that's something that was difficult about that young lad being kept in seclusion for a long time. It was a very difficult case."

Reference 11: Antionette talks here about being person centred and working around the ward culture:

"MQ I'm wondering if that's part of what really makes a difference with OT is that you might be like you said, being centred on the person instead of the system..

A yes, definitely, and I think having the confidence to be able to work around it as well. It is quite hard, but most of the time it is doable. And I think it is what people want us to be doing as well. Because I think it's easy for a system to just be kind of "this is what we do" it's useful to have a few people in their that encourage the system to do things a bit differently and finding other ways".

Dianne also talks of being child centred:

"It's about having basic respect of children and sometimes it's easy for professionals to almost not see the child and see the system around the child. You know, communicate with their parents rather than the child, answer the telephone, if it rings in the middle of appointment with a child..."

Reference 12: Di advocating for system changes to meet the child's needs:

"MQ it sounds like there's what's the child needs and what the system needs and that there are times when what the child needs, in your view is that really safe space. Actually, what came to mind was like a confessional. You know that absolute confidentiality almost somewhere where they can say anything and there'll be no response, because that's just what they need

Di and it is so difficult because I've worked with quite a few children over years to have been extremely traumatised and extremely troubled and can't move forwards at all. And you know they need that space, you also know that and they know that if they do really talk to you about what's happening for them, everything else around them falls apart and you can do, you know you can counsel them, you can talk about that, but in that child's mind they are not ready to make that disclosure because of the implications that it would have on their whole system, and as a professional if they did, you knew you couldn't keep that confidential, you have to instigate safeguarding proceedings and it is essential.

And that said, at the beginning of any therapeutic chat which work with the jargon, no matter how what, how old they are, not even if they're very little. in some form, I talk to them about, you know what information is shared and the having to communicate that with other people, even with a very little ones I try and have some degree of understanding that I work with other people and I'm there to keep them safe

MQ it feels a bit like you are, you know, you can see what the child needs and you are kind of having to navigate them through a system that may not meet what they need. (Di -Yeah) So it's making me wonder if the system should change.

Di – Yes"

Reference 13: practicalities

MQ: So on a practical level how often would you see her and for how long?

A I was probably seeing her for eight or nine months or something like that, probably every week. Then eventually after a little while she did start to become involved but there was just layers and layers and layers of just barriers that she, I suppose held her back from a being able to participate really.

Reference 14: Grace and Di on Importance of working at the child's pace, not having enough time the way services are commissioned.

Whilst Grace was able to stray beyond the commissioned service, Diane made a point of raising her concerns about therapists not having enough quality time and the importance, shown in research, of working at the child's pace:

"I think what I would probably like to highlight first is the amount of time it can take to engage children who are extremely troubled and that I feel that that that isn't available as much now for therapists. And I would like to highlight that I feel that now my work is lacking quite considerably because I don't have the quality of time that I used to have to spend with children and I think a lot of traditional research around play and how children use play and how children use the therapeutic relationship has highlighted that you know, it's a process that's should never be hurried and is a gradual process that takes time to evolve and it has to be very much at the child pace. Some children can engage very quickly in therapy and can actually use activities and the environment to gain a major emotional understanding quite quickly, but for other children, it's a slow process. It shouldn't be hurried along and can actually take substantial amount of time before you actually get to a point where you feel that that child has made a connection with you and the material that you're working with, and is able to gain some understanding of what's happening to them really." Diane

Appendix 19: Becoming & Occupational Deprivation

Findings Chapter for Nvivo Analysis 28 March 16 - 7 references coded

Cross ref Occupational Alienation with Quotes – 7 results:

Reference 1: Stability

MQ so you're helping to preserve all his placement were every years if he's at school or at home . You are trying to extend his stable times.

C so it came at a time and I hadn't seen him for a while, and he was there and it sounds really good, I was going on holiday. He was doing normal things. So maybe this is the time where we might think about you might not have to come to see me anymore, and I thought that was a good thing. And he burst out crying and obviously no one expected it. Everyone kind of looked, bear in mind we have talked about dependency, didn't we, about dependency with the previous kid. I'd.. and he said 'I don't know why I'm crying, but you're the person that I've known the longest in my life and I don't know what I would do if I lost you'. And I thought okay then we'll talk about this, as there were lots of people there. 'Let's talk about this another time but I'm not going anywhere yet'. And that was difficult because had I created a dependent, but I couldn't think of any other way I could have run with this case under the circumstances...

MQ You know in terms of the team had people thought that you where the consistent thread through all these different changes. An important part of his stability.

C because rejection was a really powerful component. He had been rejected from much of his life and what that meant to him, really."

Cath wwent on to talk about her emotions:

"C Christmas just gone was the second Christmas ever, with the same family, his has had a Christmas for more than once and how poignant that was for him. the children usually have their own little box which goes around with them. And he had some Christmas decorations that he had made in his sessions. And he's asked is carer this time 'can he take his Christmas baubles out of his box and put them with the family box'. Wow, the carer cries when she talks about that me an' all! that's really lovely. So I really want to try and protect this placement as much as possible . So I work with her as well

M in your OT role?

C in my OT role.

Occupational therapy sessions over years had clearly had a significant impact on the teenage boy and on the OT, in terms of how they related to each other. The same OT gave an endearing aside about seeing this lad she was still working with after 8 years, in a waiting room, like she was proud of him becoming a man:

“MQ So you are not his OT any more, so to speak.

C No. But he knows where I am. I saw him in the waiting area last week and I said “how are you doing” and you know he’s got a little bit of moustache happening over his lip and his voice is really deep ...”

There is no doubt that these examples show enduring trusting relationships being formed between OT and child and vice versa.

Reference 2 - 0.38% Coverage

Bernadette described their OT space:

“We are limited to space that we have, but we do have a small OT room that we’ve been able to protect. It’s bright it’s got a nice big window it lets light in. The windows on the ward are all darkly tinted glass that people can’t see in, makes it feel that bit darker inside, so the OT room is a nice light room, you can have a window you can see the trees. You can watch people walking the dogs. We have a lot of conversations about that, just sort of noticing the outside world and what there is out there .. what’s going on. Yeah. She sort of enjoys that, she likes nature, I think she’s sort of... just the light makes the difference.”

Reference 3 - 0.56% Coverage

Antionette talks here about being person centred and working around the ward culture:

“MQ I’m wondering if that’s part of what really makes a difference with OT is that you might be like you said, being centred on the person instead of the system..

A yes, definitely. And I think having the confidence to be able to work around it as well. It is quite hard, but most of the time it is doable. And I think it is what people

want us to be doing as well. Because I think it's easy for a system to just be kind of "this is what we do" it's useful to have a few people in there that encourage the system to do things a bit differently and finding other ways".

Dianne also talks of being child centred:

"It's about having basic respect of children and sometimes it's easy for professionals to almost not see the child and see the system around the child. You know, communicate with their parents rather than the child, answer the telephone, if it rings in the middle of appointment with a child..."

Reference 4 - 0.98% Coverage

MQ it sounds like there's what's the child needs and what the system needs and that there are times when what the child needs, in your view is that really safe space. Actually, what came to mind was like a confessional. You know that absolute confidentiality almost somewhere where they can say anything and there'll be no response, because that's just what they need

Di and it is so difficult because I've worked with quite a few children over years to have been extremely traumatised and extremely troubled and can't move forwards at all, and you know they need that space, you also know that if and they know that if they do really talk to you about what's happening for them, everything else around them falls apart and you can do, you know you can counsel then you can talk about that, but in that child's mind they are not ready to make that disclosure because of the implications that it would have on their whole system, and as a professional if they did, you knew you couldn't keep that confidential, you have to instigate safeguarding proceedings and it is essential.

And that said, at the beginning of any therapeutic chat which work with the jargon, no matter how what, how old they are, not even if they're very little. in some form, I talk to them about, you know what information is shared and the having to communicate that with other people, even with a very little ones I try and have some degree of understanding that I work with other people and I'm there to keep them safe

MQ it feels a bit like you are, you know, you can see what the child needs and you are kind of having to navigate them through a system that may not meet what they need. (Di - Yeah) So it's making me wonder if the system should change.

Di – Yes"

Reference 5 - 0.75% Coverage

Bernadette describes here a difference in risk taking approaches on the ward compared with OT, which impacts on the young person in occupational therapy:

“Bernie: you know this person in particular her, it's quite difficult, but I think although she is able to do that within our session it is because it's been allowed from, almost from, the beginning and obviously I've had it agreed from the MDT and it's all been risk assessed that she can access those things. But on the ward, it's a very specific thing that many people don't have access to. Then is gradually introduced and something happens that will be then you get the step back.

MQ Is that a global thing of having it and then if there is a risk it is withdrawn?

Bernadette Yes, yes it's an issue for her on the ward. If people get sort of access to certain things. It's deemed as a sign of improvement and she's very much sensitive to that. So, so that happening would she be showing to staff that she wouldn't be doing that well and she shouldn't have access. She's ready to move on now and she's quite vocal. My recommendations are that when she does move on she needs a positive risk-taking approaching. Trying things at the beginning and taking positive risks. When you take things away from her. That is seen as very hard - to reduce them, at a general level

Reference 6: Chris & Empowering OT environment vs authoritarian ward

Understanding the CYP's behavioural problems after OT sessions and the child's

need for time to psychologically process the change from what happens in

occupational therapy sessions to the ward environment is described here by Faith:

“that was a huge learning curve for me as I was like ‘what's going on, what's happening’ but she needed time to process, because processing skills are so so slow, she needed time to come away from that really empowering session to then come into an authority, rules led environment.”.

Reference 7: Bernie on OT Positive Risk Taking vs Ward Risk Aversion

I think it's interesting enough that I had had a conversation with a member of staff ward staff prior to that around trying to make sure there was a care plan there.

That their care plan was to make sure there was an AWOL procedure, the history. It was all the kind of the formalities and the kind of... It didn't seem to have much therapeutic value in it for me and I think that sort of whole risk-taking, the initial reaction is to think about.. what has, what could go wrong. I understand why ... that would be the case, there's a lot of activities. There are a lot of discussions about swimming as an activity and very, very different opinions across the MDT as to whether it's appropriate, whether we can do it, whether the staff can swim or can't swim. I think as OTs we look at the positives of what some people would get out of that. Yes we don't discount that, you know, things could go wrong because they can, but we also think of how we balance that with what the young person will benefit from and the therapeutic value of it."

Appendix 20: Reflexive Quotes

Quote Number	Full Text Quotes
1	<p>On 18/11/2013 a research diary entry highlights:</p> <p>“There has been a subtle change in my own identity from manager to researcher, hence a change in the research question from why not using outcome measures to wanting to understand the deeper issues behind clinical effectiveness in children services.</p> <p>The shift from objectifying the CAMHS OTs, as a non-compliant group, and from the researcher as expert in knowing what needed to happen, to seeing greater complexity and the OTs as experts in helping to uncover such “deeper issues”.</p> <p>I don't think anyone has actually asked CYPs OT what they think about clinical effectiveness and the use of outcome measures. I think CYPS commissioners ask for a lot of outcome measures already e.g. 300+ in the national data set. So reflecting on my journey I am more interested in understanding the truth for OT's (what they) think and believe. In checking out my managerial presuppositions on what OT should be doing and how I can help them to do it. I was going to do a pilot implementation strategy but on reflection of the feedback from the proposal I want this to be proper research rather than an action research method. It's nearer to doctorateness and properly research the phenomenon based on a gap in knowledge, then attending to an immediate practice issue.”</p>
2	<p>Mentoring session on 17/2/2014</p> <p>“I have grappled with the research question and the positivistic nature of outcome measurement. I have done a pilot (at work), asking staff about determinants of practice and what the barriers were to implementing evidence based outcome measures. Following this I realised that OT staff generally feel shame, they know they should use such things but don't know them or don't care about them...that this shame factor is likely to skew any results. It is a question arising from fear and fear is a poor motivator, for example my concern for the future of OT services, i.e. my own position as manager and “prizing my manager hat off”.</p>
3	<p>Unlocking the secrets of power - a reflective account (19/2/14):</p> <p>“I have awoken to the politics of research as I struggled with my research question have gone from ‘why, when they use outcome measures’ then ‘I wonder what they really think about outcome measures, positivistic tool driving the question’ to “when do OT</p>

	<p>using children services feel they're most effective" their agenda, not mine as a manager, mine as an OT researcher wanting to unlock the power of therapy instead of facilitating the agenda of those in power to measure these outcomes. The methodology question the answers this motivation is all about politics of empowerment, this will need to be an important part of my reflexive journey"...</p>
4	<p>Examples from interviews show this process in action:</p> <p>Emily (OT): "Sometimes they feel like they're stuck, don't know where they are going... She paced constantly, so you see in this big gym, a teenager played skittles which involved me having to set up these ridiculous plastic things (skittles) which fall over at the drop of a hat..."</p> <p>MQ: "Been there, done that!"</p> <p>E: "I set them up in the shape for her to fire the ball, to whack them down and then pace. I set them up again and that went on for some months we offered twice a week which, for what felt like an eternity of putting these stupid little skittles. I can see them now, I can feel them. There are like embedded in my cells in my hand. And I was able to say to her how frustrating that was and how, it didn't seem to have any purpose. I put them up. She knocked them down. I put them up, she'd.... It just felt like it was dark in this cycle and that we couldn't move and then it made no sense and I didn't understand it. She was again an anorexic 13-year-old very academic, very bright and she just said, but that's how I feel about anorexia. Because we had externalised anorexia for her, which is like a family therapy type technique, is where you give it its own character and so she called it anorexia and she was able to say that is how I feel. And then we were able to move on actually after that, somewhere in her own unconscious thought she was giving me her experience of what it's been like to be anorexic. I would've given it (away), pass to another therapist and one of the nurses said... I'd like to work with her. I think they're the ones you need to have your supervision over, the ones where you feel like you don't know what you're doing, you're stuck, you're lost..."</p> <p>MQ: "It strikes me as quite an altruistic act in the end. I've had those kids whack those skittles over, you know it's just so heart rendering, it's so soul destroying, it feels like that at the time doesn't it? What is this all about?"</p> <p>E: "It is, isn't it? It goes on forever; you look at your watch, another 2 min (laughing)..."</p> <p>MQ: "(laughing) It makes you laugh a lot because I remember that feeling so much, but there is something about this level of perseverance that seems...feels so important...there's something that is more important than you escaping."</p> <p>E: "Completely."</p>

	<p>MQ: "It sounds to me like it's about sticking with the child."</p> <p>E: "I think because even though it's difficult, but you make connections with young people, you wouldn't be in the job if you didn't and you know that these young people have never had people that have stuck with them. They've always been passed on, one school can't manage they get past on. Teachers come and go. You know working in Tier 4, there's nowhere to pass children onto, you deal with what you deal with. You've got to persevere and sometimes you feel like you can go on for weeks with nothing."</p>
5	<p>Co-construction</p> <p>MQ: "At some stage I'm interested to know if you feel like there is a metaphor or a picture that might sum up, when occupational therapy is really effective, you know... That's like what? Does it illicit a thought or a picture or a metaphor for you?"</p> <p>Di: "I keep thinking of a rollercoaster, because that's how I feel about working with kids, it is when you actually connect with them and you can see the change, it's absolutely amazing. It's just, the best feeling ever, when you make that connection and you can see progress and development and you can see the children are kind of setting off down a path that is better for them, that they have chosen and they have had a part in. That's amazing.</p> <p>And that's the highlight but then the low bit is kind of really quite horrific in managing the kind of dynamics around working with children and the emotional processes, the risks, the legal system around kids. ...you know, the research is there, risk and resilience theory, why aren't we investing in children? ..."</p> <p>MQ: "Is there anything out about the rollercoaster...you know when you think about that rollercoaster ..has it got any other things about it?"</p> <p>Di: "I think it's got something around it like a container, I think it's, you know, you have to ride the rollercoasters when you're working with children but you need to have... you know you just come off the end if you didn't have some kind of overarching structure around you, to keep you safe. So, I think you know, again... I'm going back to early psychological theories but the "container contained" you know, I think you need to use that model in supervision, in teams, and again, if that fails, then that's where you have serious, serious difficulties.</p> <p>So I see it as a rollercoaster with a big kind of container around it which would kind of keep you safe while you're working."</p> <p>MQ: "So, it's a rollercoaster... you can see it easy through the container. If you saw the rollercoaster in the container would I see the rollercoaster? or ..."</p> <p>Di: "Yes, you probably see the rollercoasters and I think you'd see, just like an aura of film you know something to keep everything in there, you know if you are not able to be contained in amongst to the highs and the lows, by all means celebrate the</p>

	<p>highs with the families and the kids, you know you can share the progress, but if you can't contain the lows, it's not helping anybody. Families need you to be their container, so you need someone to contain you doing that work. I think we do have that, we do have that. We tend think of success interventions as, I don't know, the highs where maybe... when people achieve their goals of what they wanted to do, but you don't always think of the successful intervention as “containing the lows”, you know, that actually, it was really, really difficult but what we did was contain it, that was the success, you know.”</p>
6	<p>“29/10/2014 (Int 2) Bernie. Post interview researcher notes.</p> <p>There appear to be themes around positive risk-taking as well as highly graded risk assessment. The OTs communication style seems to be key and the drive to be consistent along with use of both verbal and non-verbal methods of communication and creative methods in activities. The OT appears to hold hope for the child and others. The key positive or assessment of effectiveness appears to be when the child makes links between sessions and people to linking in and out of sessions. There's the concept of OT time and privacy and dignity which appears pivotal. The opportunity for the child not be scrutinised checked ...</p> <p>There was a reference within the discussion to my managerial role and the occupational therapy leaflet which the children have been asked to provide feedback on. For me personally the researcher role felt more comfortable with the familiarity with a clinician and clinician discussion. I asked questions around age of diagnosis which was my own need to be able to understand the problems within my previous schema and was an example of when I was struggling to bracket to my previous knowledge and understanding and interestingly this appeared to reflect a dynamic with the ward – where the ward sees the child's diagnosis and the problems, whereas the OT is seeing the child and the solutions.”</p>
7	<p>Co-Construction</p> <p>MQ: “That something important has happened when you feel it in your heart has that got a size or shape or colour is there anything about it. Has it got certain attributes?”</p> <p>E: “It feels like a heavy feeling but I don't know why, you'd think it would be a light happy feeling. But it's heavy because it's important solid...solid. It feels like a solid circular kind of spherical shape you can just feel there. And it's red, I don't know why it's red. I can feel this red sphere... just here.</p> <p>It's static that you'd think it would flutter or beat or move or something but it's just a solid, round solid shape...</p> <p>Not really no, it's just, I don't know. It feels like... This is really hard. I've never even thought about this before but I can picture it now you've taken us to it.</p>

	<p>I think it's solid rather than light and airy and happy. it just feels like it's something really big and important, something you can grab a hold of, is like physically there. Grounded sense about it. Maybe it's something to do with, you now there's been some breakthroughs or understanding of what's happened and it feels like you've made some kind of solid connection or sense of what is maybe that's why it's a solid shape. There's something quite grounded, some sort of evidence of what you think of what you feel. Don't know..."</p> <p>MQ: "What comes just before that solidity?"</p> <p>E: "That, you breathe it in, and then it's there, you get goose pimples and then you just feel it. There, just below your heart."</p> <p>MQ: "How does it feel evoking it?" (<i>I was annoyed with myself at the time, for asking a loaded question, instead of keeping with clean questions</i>)</p> <p>E: "It's neither nice nor uncomfortable. I don't know Maria, it hasn't got a negative attachment to it but it's not like all happy and joyful either because it is sometimes what, sometimes the reality of what you're feeling sometimes this isn't nice, it isn't a nice thing. It wasn't nice for that little girl to not have a mum to do her hair. I think it's, feels quite serious, it doesn't make sense really cognitively, but it feels, is something to be taken, it feels important. It's big and heavy and serious, it's a solid mass. Some kind of realisation that something big and important has happened is, I think that's how I would probably describe it. It's not really an emotion it is, more like a description. I don't know, I don't feel an emotion."</p>
8	<p>MQ Diary a research memo in NVivo January 2015.</p> <p>"I asked occupational therapists to describe situations in as much detail as possible where felt that the occupational therapy had been effective for the child, where there were breakthrough moments, when they knew that the therapy had made difference. In order to help them to describe rather, than interpret what they thought was going on, I asked for as much detail of possible of what was actually happening at the time (Finlay, 2011). Specifically, about the environment (where/when), behaviour (what was happening in the room/what was being said). I was interested in whether the OT would describe using particular OT skills and what professional values/beliefs might underpin such actions."</p> <p>"My first Sweep of the data is in order to understand the participant's perspective what they are trying to say what does this mean? This commenced with transcribing the interviews myself using Dragon NaturallySpeaking and repeating every word of each interview. I felt like the words were flowing through my being, it was a very moving process hearing the wonderful stories of very unwell children who had been helped by OTs. This embodied feeling was also part of my refection, as the Reflective Relational (Finlay and Evans, 2009) approach to data collection, encourages an awareness of embodied responses and what might being projected by the participant. The concept of</p>

	embodiment is also encapsulated within Ashworth's Lifeworld approach to data analysis, an approach I will also be taking..."
9	<p>Collaboration</p> <p>MQ: "You are saying about being really tuned into the non-verbals. I remember sessions, I can't imagine how that felt for you over a long period of time because I remember sessions with children that were mute, and it's actually excruciating - one hour's session would feel like forever."</p> <p>F: "Yes, it's painful."</p> <p>MQ: "Yeah, yes a 10 minutes session can make you feel really uncomfortable."</p> <p>F: "It makes you think of your observation skills and about taking you back to your roots. Actually, it gives you a chance to observe someone and what their behaviours are, how their functioning, what they're doing, how important was it to them. And actually, you get a lot more from non-verbals. There's a lot of research about non-verbals speak louder than words, and sometimes I think it's just about revisiting that for myself. ... I felt really stuck with this young person. And that's my anxieties and expectations and put onto the young person and trying to move them on quicker and and that's my personality traits. I want job done, right move onto the next one. I think she has really being quite useful for me to reflect upon, how I engage people and how it's all right to take time, it's all right to not do a lot, and I think she's just given me that. I've been able to, when I sat there and now when I write a report am actually been able to clinically justify why I'm doing these sessions.</p> <p>It's made me look at my own clinical skills and I've had the richness of working with her for a couple of years. I've had a lot of time to think about her. I probably don't think that she thinks about me that much!"</p> <p>MQ: "There is something that, there is quiet a, firmly there is quite a level of altruism to be in that position. That position when you're thinking this is feeling very uncomfortable to being quiet and a silent session, and you describe that and I can recall that from my practice, and you kind of think, that over the extended period of time. All the questioning, self-questioning that you've gone through, there is something altruistic about that isn't there because it would have been so much easier, in some ways, for you to keep your positional power and are not rock your clinical boat, but she wouldn't have got what she has done out of it. It's a big thing to give her, which, it's probably has its own toll on you. I suppose."</p> <p>F: "Yes, I have come away to the team, they have been a great support, because it's a safe place to be able to say "what the chuff am I doing?" (laughing) How many times will I have to get cards are making materials? It's exhausting, it is absolutely exhausting. But you kind of kind of have to go through all of those emotions, and it does feel very normal and, I have felt frustrated and I've felt</p>

	annoyed. I felt, I just want to get this done, but I just had to stop and just say 'it's okay, it's all right'."
--	--

Appendix 21: Rollercoaster Rap

Life's Rollercoaster Ride

Verse 1:

C'mon join, c'mon join, c'mon join life's rollercoaster ride,
Step on board, no need to hide,
There's a world of op-or-tunity waiting to greet you,
It will seem to take a while to see results, but don't be fright-ened,
You'll soon realise why not earlier; your senses will be height-ened.

Chorus:

Roll, roll, roll, with life's robust rollercoaster,
When you've finished the bumpy ride, you'll hop, skip, jump, oh what a boaster,
Every twist, turn, up-hill and down, it starts off like an earthquake,
But believe me when you get to the end, your light and as calm as a still-lake,
So off you go, you're dis-charged, go forth and spread your wings,
Your absolutely free as a dove, go and see what your new health brings.

Verse 2:

We'll empathise, we'll sympathise, we'll support you all the way,
We'll encourage and protect you, we promise you won't be dismayed,
Your potential is lying dormant, all kids have abundance, we guarantee,
But you gotta believe and let it out, lend us your ears and listen to our plea.

Chorus:

Roll, roll, roll, with life's robust rollercoaster,
When you've finished the bumpy ride, you'll hop, skip, jump, oh what a boaster,

Every twist, turn, up-hill and down, it starts off like an earthquake,
But believe me when you get to the end, your light and as calm as a still-lake,
So off you go, you're dis-charged, go forth and spread your wings,
Your absolutely free as a dove, go and see what your new health brings.

Verse 3:

One, one, one, we are inter-locked like a tightly woven basket,
I follow my leader's direction, the one who I trust implicitly,
I'm feeling better, I'm part of the global puzzle, my confidence would fill a casket,
The vision is clear, a new path laid, no budget on good health, made ex-plicit-ly.

Chorus:

Roll, roll, roll, with life's robust rollercoaster,
When you've finished the bumpy ride, you'll hop, skip, jump, oh what a boaster,
Every twist, turn, up-hill and down, it starts off like an earthquake,
But believe me when you get to the end, your light and as calm as a still-lake,
So off you go, you're dis-charged, go forth and spread your wings,
Your absolutely free as a dove, go and see what your new health brings.

Verse 4:

The empty seat is waiting, its vacant but not for long,
Whose next to break out from that shell, listen! There goes the gong,
Life's engine is revving, the rollercoaster's race is on, to a healthier situation,
It won't leave without you, you can do it, unleash your determination.

Chorus:

Roll, roll, roll, with life's robust rollercoaster,

When you've finished the bumpy ride, you'll hop, skip, jump, oh what a boaster,
Every twist, turn, up-hill and down, it starts off like an earthquake,
But believe me when you get to the end, your light and as calm as a still-lake,
So off you go, you're dis-charged, go forth and spread your wings,
Your absolutely free as a dove, go and see what your new health brings.

Quinn, M. (2016) *'Life's Rollercoaster Ride'*©. Edited by Deborah Stoker.

Appendix 22: Toolkit for Occupational Therapy Outcomes

Notes for OTs:

1. Recent research I have carried out has identified a need for a way of capturing both the views of CYP and also OTs regarding effective occupational therapy. This toolkit is a next step from the research, to pilot their use and utility in practice. A workshop will be run to share the findings of the research and these early thoughts on how to support OTs to assess the effectiveness of the occupational therapy being offered.
2. The aim of this tool is to prompt you to consider seeking feedback and then considering the responses, regarding some key areas of enquiry which arose from a research study of effective occupational therapy.
3. The categories of feedback are informed by service user feedback undertaken by the Picker Institute (Picker Institute Europe, 2015). The images I have created and you can use freely.
4. It aims to simplify getting and using feedback, as standardised outcome measures were not always found to be as child centred as clinicians' wanted them to be and may not capture the holistic view of the young person.
5. This more informal, flexible approach aims to bridge the gap between having limited means of consistently evaluating the effectiveness of occupational therapy from a child centred, holistic, OT perspective.
6. Feel free to alter the wording according to the developmental, intellectual and communication capabilities of the CYP.
7. Feel free to select which questions to ask, out of a range of options offered
8. Please add your own questions, as areas you consider are significant to providing effective occupational therapy are identified.
9. HCPC Standards for CPD require all OTs to provide Effective Occupational Therapy and meet the five standards set out. This form can be used as supporting evidence that you meet all five of the required elements:

1. “maintain a continuous, up-to-date and accurate record of their CPD activities” – ***this dated and HCPC registrant coded form provides you with a written record of this activity as part of your CDP***
2. “demonstrate that their CPD [activities](#) are a mixture of learning activities relevant to current or future practice; - ***these questions and the overall toolkit will require you to do different things – reflect alone, talk in supervision, and communicate with service users and carer and MDT.***
3. “seek to ensure that their CPD has contributed to the quality of their practice and service delivery;” ***By filling in the clinician forms (CROMS and CREMS) it is explicit that you are considering your practice to improve it, which is a quality practice and service endeavour.***
4. seek to ensure that their CPD benefits the service user; and - ***by asking CYP and families for feedback (PROMS and PREMS) it is implicit that you are thinking about quality from their perspective.***
5. “upon request, present a written profile (which must be their own work and supported by evidence) explaining how they have met the standards for CPD.” ***The toolkit forms when signed and dated are evidence that you can draw upon if and when you have to submit a written profile. It is good practice to write a yearly profile for your appraisal, so that you can plan the next years CDP priorities.***

(Health Care Professions Council, 2012)

10. The left hand column codes F1-15, relate to a visual summary of a research project which identified these as key areas for effective occupational therapy. This image should be attached to these feedback forms, if not, it is available from: Maria.Quinn@ntw.nhs.uk, along with further information about the research study. Feedback and comments on using these forms are also welcome, and sharing across networks valued, let me know if you're interested in being part of Effectiveness in OT Network (with CYP with MH/LD).

11. Action Plans from feedback. Total up the number of ticks in each column. Of the ones which show most disagreement (red), look to see if there is a theme. Repeat for each column and overall. Select out 5 areas which you will prioritise for action. List them in the table.
- 12. For the same topic areas.eg. Enhancing Doing – Bring together the top 5 PROMS/PREMS and then the Top 5 actions for CROMS/CREMS. See if there are themes across the two priority tables. Decide on you actions and summaries in table with a date for completion.**
13. **You now have a prioritised table of how you are going to improve the effectiveness of occupational therapy based on the young persons and your own feedback.** Date and complete your HCPC registration number. Please consider involving CYP/families/supervisor in seeking solutions to improve the OT Service.
14. If you are asked whether the occupational therapy you offer is effective, you can draw upon the Feedback collated to highlight strength areas. You can also show you table of priorities, for further work to enhance your OT sessions. You can bring this information to supervision, appraisal or provide HCPC with it, if they audit your practice. If a complaint is raised about your service you can show how you respond to feedback and past actions which have resulted in improved services.
15. Please share your feedback and progress with CYP, families, the MDT, commissioners and the wider CYPS OT community, so that we can demonstrate the effectiveness of occupational therapy as an intervention.
16. If you are interested in becoming involved in a **CYPs Effective OT Network**, please email maria.quinn@ntw.nhs.uk. By drawing together our ideas we can make OT more effective for the CYP

Top 5 Priority Areas from PROMS/PREMS Feedback:

	Area of Concern	Action Planned	Results/Date Complete
1			
2			
3			
4			
5			

Top 5 Priority Areas from CROMS/CREMS Feedback:

	Area of Concern	Action Planned	Results/Date Complete
1			
2			
3			
4			
5			

Date

Name






OT HCPC Registration Number:

Appendix 23: PROMS/PREMS: Enhancing Doing

Questionnaire and Action Plan

A Toolkit for Occupational Therapy Outcomes:

Children & Young Peoples Feedback

							
F1	1	Did you lead today's OT session?					
F3	2	Was it available when you wanted it?					
F3	3	Are the sessions too short?					
F3	4	Are the sessions too long?					
F3	5	Were you provided with regular occupational therapy?					
F3	6	Did you choose the place where you had OT?					
F3	7	Did your OT session happen as planned?					
F4	8	Were the OT sessions useful for you?					
F4	9	Did you make something					
F6	10	Did you feel you had the opportunity to express yourself whilst doing activities?					
F6	11	Were you offered an alternative to talking therapies?					
F6	12	Were you comfortable with the proximity of the OT to you?					
F6	13	Were you comfortable with the contact you had with the OT?					
F6	14	Did you and the OT alter or grade activities so you could do them well?					
F6	15	Did the OT play at your level?					
F7	16	Were you experiencing sensory overload?					
F7	17	Were you offered activities off the ward/within the community?					
F7	18	Did you have the opportunity to access restricted activities, which would otherwise be locked away or off-limits?					
F14	19	Did you do an activity/occupation?					
F14	20	Did you do a new activity/occupation?					

Enhancing Doing Incorporates:	
F1:	Child centred
F3:	Time & Space
F4:	Grading & Adapting activities & Environment
F6:	Doing
F7:	Occupational Imbalance
F14:	Occupation
Please see Flower Attached Maria.Quinn@ntw.nhs.uk	

Please Tick (one only)	
	I agree a lot
	I agree a bit
	I can't decide/ I don't know
	I disagree a bit
	I disagree a lot

Top 5 Priority Areas from Feedback:

	Area of Concern	Action Planned	Results/Date Complete
1			
2			
3			
4			
5			

Date

Name






OT HCPC Registration Number:

Appendix 24: PROMS/PREMS: Enhancing Being

Questionnaire and Action Plan



A Toolkit for Occupational Therapy Outcomes:

Children & Young Peoples Feedback

							
F1	1	Did you decide on the main things you did in OT?					
F1	2	Did you feel in control of the OT session?					
F1	3	Did you feel like you could say what you wanted in OT?					
F1	4	Did you feel like you could do as you wanted in OT?					
F2	5	Were you treated fairly?					
F2	6	Did you feel cared for?					
F2	7	Did you feel respected?					
F2	8	Did you feel you had a trusting relationship with your OT?					
F2	9	Did you show or tell anyone about what you did in OT?					
F2	10	Did you link in and out of OT sessions by reporting back on progress between sessions?					
F2	11	Did people comment on what you did/made in OT?					
F2	12	Are your relationships with others, how you want them to be?					
F3	13	Have you attended OT consistently/regularly?					
F3	14	Was OT available when you wanted it?					
F3	15	Did OT happen as often as you wanted it?					
F3	16	Are the sessions too short?					
F3	17	Are the sessions too long?					
F3	18	Have you raised concerns when OT sessions haven't happened?					
F8	19	Did you feel safe in your OT session?					
F8	20	Did you feel you had the opportunity to express yourself whilst doing activities?					
F8	21	Did OT help you to find your voice and say what you wanted?					

F9	22	Did you feel less isolated?					
F9	23	Did your oT stick with you during transitions? (eg change school)					
F9	24	Did your OT see your potential and uniqueness?					
F14	25	Did you do learn a new activity, that you valued?					

Enhancing Being Incorporates:	
F1:	Child centred
F2:	Authentic Relationship
F3:	Time & Space
F8:	Being
F9:	Occupational Alienation
F14:	Occupation
Please see Flower Attached Maria.Quinn@ntw.nhs.uk	

Please Tick (one only)	
	I agree a lot
	I agree a bit
	I can't decide/ I don't know
	I disagree a bit
	I disagree a lot

Top 5 Priority Areas from Feedback:

	Area of Concern	Action Planned	Results/Date Complete
1			
2			
3			
4			
5			

Date

Name






OT HCPC Registration Number:

Appendix 25: PROMS/PREMS: Enhancing Becoming

CYP & Becoming – Questionnaire and Action Plan

A Toolkit for Occupational Therapy Outcomes:

Children & Young Peoples Feedback

							
F1	1	Did you do what you planned to do in OT?					
F1	2	Did you decide on the main things you did in OT?					
F1	3	Have you decided to regularly attend OT?					
F1	4	Have you missed any OT sessions?					
F1	5	Was it available when you wanted it?					
F1	6	Did it happen as often as you wanted it?					
F1	7	Are the sessions too short?					
F1	8	Are the sessions too long?					
F4	9	Were the OT sessions useful for you?					
F4	10	Were they successful for you?					
F4	11	Were they pitched at about the right level					
F5	12	Were you own goals met by OT session?					
F5	13	Have you and the OT got an agreement that you both attend every session?					
F5	14	Did you have the opportunity to multi-task and be challenged by the complexity of the activity?					
F5	15	Were the goals for this OT session clear to you?					
F5	16	Were you hoping to achieve something important to you?					
F5	17	Did you achieve what you wanted to?					
F5	18	Was the aim of the session, your choice?					
F5	19	Did you indicating preferences non-verbally?					
F5	20	Are you getting quicker at making decisions in OT?					
F5	21	Do you feel like your mixing better with other people?					
F5	22	Have you used certain activities, such as play to choose to let the OT know what's bothering you?					
F5	23	Have you had opportunities to try new things?					
F5	24	Are you doing more at home/ward/school?					
F5	25	Are you choosing to do new things, based on what you've learnt in OT?					

F5	26	Have you identified and working on independent living skills?					
F5	27	Have you established routines and habits with life skills such as: <ul style="list-style-type: none"> • independent travel; • cooking skills; • getting fit; • opening a bank account • returning to school/ family environment • Becoming an expert in yourself • Building emotional resilience • Helping others • Getting qualifications • Duke of Edinburgh's awards • Making friends • Having fun • Having hobbies and interests 					
F10	28	Were you working on a goal to get back to school or home?					
F10	29	Were you working on goals about participating more?					
F10	30	Was the place you had OT, chosen on purpose for what you wanted to do?					
F11	31	Did your OT help you Engage in Activities?					
F11	32	Does OT allow you to try new things you cannot normally do?					
F11	33	Are you in control of the goals of your occupational therapy?					
F11	34	Have you Counterbalanced Pressure with Fun in OT?					
F14	35	Did you learn a new activity, that's important for your future?					

Enhancing Becoming Incorporates:	
F1:	Child centred
F4:	Grading environment and activity
F5:	Goal Setting
F10:	Becoming
F11:	Occupational Deprivation
F14:	Occupation
Please see Flower Attached Maria.Quinn@ntw.nhs.uk	

Please Tick (one only)	
	I agree a lot
	I agree a bit
	I can't decide/ I don't know
	I disagree a bit
	I disagree a lot

Top 5 Priority Areas from Feedback:

	Area of Concern	Action Planned	Results/Date Complete
1			
2			
3			
4			
5			

Date

Name






OT HCPC Registration Number:

Appendix 26: PROMS/PREMS: Enhancing Belonging

Questionnaire and Action Plan

Toolkit for Occupational Therapy Outcomes:

Children & Young Peoples Feedback

							
F1	1	Have you and the OT got an agreement that you both attend every session?					
F1	2	Have you attended OT consistently/regularly?					
F1	3	Have you missed any OT sessions?					
F1	4	Have you raised concerns when OT sessions haven't happened?					
F1	5	Did you feel like you could say what you wanted in OT?					
F1	6	Did you feel like you could do as you wanted in OT, within the safety rules?					
F1	7	Were you working on goals about relationships? (friends and family)					
F2	8	Did you feel cared for?					
F2	9	Did you feel you had a trusting relationship with your OT?					
F2	10	Did you link OT sessions with things outside OT (like the ward, or home).					
F2	11	Did you link in and out of OT sessions by reporting back on progress between sessions?					
F2	12	Did you invite the OT into other sessions?					
F5	13	Do you feel like your mixing better with other people?					
F5	14	Whilst you're doing activities (like cooking) have you learnt how to get support, or find your voice?					
F5	15	Are you doing more at home/ward/school?					
F5	16	Have you established a role at home family that you enjoy?					
F5	17	Have you managed key life transitional points?					
F12	18	Has your OT helped you to make connections with friends and family, so that you feel you're doing what you want to?					
F12	19	Did you feel like the level of bodily/environmental freedom was right?					

F12	20	Have you increased your level of participation i.e. Doing more things and being more involved with doing things with others?					
F12	21	Has your OT helped to facilitate your communication and activities with significant others (friends , family)?					
F12	22	Have you helped develop a sense of community and citizenship?					
F12	23	Did you transfer things you learnt how to do, into other environments (e.g. Sharing things you've made like cakes/cards, ideas about doing things)?					
F12	24	Did you make or do anything in OT that you later shared with others?					
F12	25	Did you show others what you did in OT?					
F12	26	How did it feel to share what you had done in OT?					
F12	27	How did the feedback make you feel?					
F12	28	Would you do anything differently next time as a result of the feedback you received?					
F12	29	Are you more selective about how you are with different people?					
F12	30	Are your relationships with others, how you want them to be?					
F13	31	Has your OT offered alternative patterns for your to access OT, that suit you better?					
F13	32	Has your OT activity sought to provide OT at times when you are unwell or isolating yourself?					
F14	33	Are you doing activities which help you to make connections with other people?					

Enhancing Belonging Incorporates:	
F1:	Child centred
F2:	Authentic Relationship
F5:	Goal Setting
F12:	Belonging
F13:	Occupational Marginalisation
F14:	Occupation
Please see Flower Attached Maria.Quinn@ntw.nhs.uk	

Please Tick (one only)	
	I agree a lot
	I agree a bit
	I can't decide/ I don't know
	I disagree a bit
	I disagree a lot

Top 5 Priority Areas from CYP Feedback:

	Area of Concern	Action Planned	Results/Date Complete
1			
2			
3			
4			
5			

Date

Name






OT HCPC Registration Number:

Appendix 27: CROMS/CREMS: Enhancing Doing

Questionnaire and Action Plan

A Toolkit for Occupational Therapy Outcomes

Occupational Therapists Feedback

							
F1	1	Was the session led by the C/YP?					
F1	2	Did you offer choice in the duration of OT session?					
F1	3	Have there been cancelled sessions on your part?					
F1	4	Did you make 'therapeutic work' feel like fun?					
F1	5	Did you adapt environments to the individual needs of the child?					
F1	6	Have you enabled the CYP to have a balance of occupations?					
F3	7	Have you got evidence that you provide regular OT sessions?					
F3	8	Have you analysed the question of 'dosage', how often and how frequently (eg. Weekly over x months, i.e. x sessions).					
F3	9	Were re-arranged sessions negotiated with the C/YP to suit them?					
F3	10	Was the C/YP offered a choice of rooms/space for OT?					
F3	11	Can others (family/MDT) help to reinforce or deliver aspects of the planned sessions?					
F4	12	Did you grade the planned activity before the sessions?					
F4	13	Did you grade the activity during the sessions?					
F4	14	Did you grade the environment prior to the session?					
F4	15	Did you maximise the grading of the activity/environment opportunities in the session, in order to facilitate them to meet their goals?					
F6	16	Did you build rapport through matching and mirroring their communication?					
F6	17	Were you noticing the child's physical movements and mirroring/move your own body to align with the movements and gestures of the young person?					

F6	18	When calibrating embodied proximity with CYP with significant MH/LD issues, did you consider/negotiate ways of sharing space with the CYP?					
F6	19	Did you provide physical reassurance through touch?					
F6	20	Did you notice any emotional impact in yourself, when progress was made?					
F6	21	Ending occupational therapy: did you make or have something physical for the CYP to take away from OT (eg. a card, a list of tips or strategies, plans and plants)?					
F6	22	Did you consider any objects from today's OT as being a transitional object (symbolising a physical connection and contact after OT)?					
F6	23	Did you establish boundaries and rules which ensure safety?					
F6	24	Have you provided opportunities for increased occupational balance addressing in all aspects of activities of daily living?					
F6	25	Have you provided an opportunity for CYP to share memories both good and bad?					
F6	26	Have you utilised particular patterns and frequencies, to convey predictability?					
F6	27	Is CYP development skill at a pace comfortable to them?					
F6	28	Have you discussed such feelings in supervision?					
F7	29	Have you experienced a sense of time distortion on OT sessions (slow or repeated activities, endless time in sessions)?					
F7	30	Have ward/ MDT staff tried to hurry the therapeutic process along due to external commissioning and pressure on beds?					
F7	31	Have you addressed issues of occupational imbalance: (e.g. creating play environments; creating developmental opportunities; providing bright and light environments)?					
F7	32	Have you provided an opportunity for access to restricted activities?					
F7	33	Have you provided environmental access to occupations?					
F7	34	Are you Bridging Transitions?					
F7	35	Are you promoting Positive Risk Taking for Rehabilitation?					
F14		Did you analyse the occupational form to enhance DOING? Eg. Cooking <ul style="list-style-type: none"> Eg. What was it called? 					

		<ul style="list-style-type: none"> • How is it done? • Where is it done? • Using what (equipment/materials)? • With Whom & When? • Capacity, Knowledge, Skills required • Outcome of activity (e.g. end product) • Meanings & Standards • Context: Sociocultural; Political; Economic; Historical • Impact on Health <p>Ref: Hocking (2013)</p>					
F15		Have you addressed issues of occupational injustice?					

Enhancing Doing Incorporates:	
F1:	Child centred
F3:	Time & Space
F4:	Grading & Adapting activities & Environment
F6:	Doing
F7:	Occupational Imbalance
F14:	Occupation
Please see Flower Attached Maria.Quinn@ntw.nhs.uk	

Please Tick (one only)	
	I agree a lot
	I agree a bit
	I can't decide/ I don't know
	I disagree a bit
	I disagree a lot

Top 5 Priority Areas from Feedback:

	Area of Concern	Action Planned	Results/Date Complete
1			
2			
3			
4			
5			

Name:

OT HCPC Registration Number:






Date:

Appendix 28: CROMS/CREMS: Enhancing Being

Questionnaire and Action Plan

A Toolkit for Occupational Therapy Outcomes:

Occupational Therapists Feedback

							
F1	1	Was the OT session child centred?					
F1	2	Did the CYP decide on what to do in the OT session?					
F1	3	Did you manage to engage the young person? B					
F1	4	Did you create a sense of control for the CYP?					
F1	5	Did you recognising the child as expert?					
F1	6	Did you identify the CYP's goals and written care plans together?					
F1	7	Have you facilitated the CYPs to evaluate their progress towards their own aims/goals?					
F2	8	did you demonstrate your respect/Care/Compassion?					
F2	9	did the C/YP respond positively to your respect/care/ compassion?					
F2	10	Do you feel you have a trusting relationship with the child?					
F2	11	Have you seen positive results from the occupational therapist providing stability for the CYP?					
F2	12	Have you noticed an emotional dependency from the CYP					
F2	13	Have you noticed an am emotional link from yourself to the child?					
F2	14	Are you sometimes surprised by strong emotions expressed by CYP in OT?					
F2	15	In supervision, have you discussed interpersonal dynamics between yourself and the CYP (and vice versa)?					
F2	16	Is your supervision sufficient to address your needs to maintain professional boundaries with the CYP?					
F2	17	Do you receive monthly supervision?					
F2	18	Do you need any CPD support to improve the effectiveness of how you utilise the authentic relationship you have built with the CYP?					

F2	19	Is the CYP asking intrusive/overly curious questions about your life situation?					
F2	20	Is there a MDT approach to the management of intrusive questions, personalised to the needs of the CYP?					
F3	21	Have there been cancelled sessions on your part?					
F3	22	Have there been cancelled sessions on the part of the MDT/ward?					
F3	23	Did you take time to soften the clinical space within which you saw the child? (eg. removing or covering clinical equipment)					
F3	24	Did you create a safe OT spaces (Monica Lanyardo), to put the child at ease and convey your respect of the young person?					
F8	25	Did you demonstrate: Altruistic Tenacity Flexible and Calm OT?					
F8	26	Did you demonstrate: Advanced Non/Verbal Communication OT Skills?					
F8	27	Did you encourage the child to lead and be the expert in themselves, recognising the CYP potential?					
F8	28	Did the OT session work on the C/YP sense of self (Selfhood)					
F8	29	Have you identified key indicators of a developing sense of self/selfhood/agency/ Identity?					
F8	30	The OT being: consistent; approachable; trustworthy; re-empowering of the child to lead sessions and be the expert in their own lives.					
F9	31	Did you resist the objectification of the child , see the CYP as an individual with potential, not as a diagnosis/behavioural presentation?					
F9	32	Did you encourage Positive Risk Taking to counter the a Culture of Risk Aversion Limiting Access to Activities?					
F14	33	Did you analyse the occupational form for its value in facilitating the child's BEING?					
F14	34	Did you specify which attributes of the occupation you focussed on to enhance BEING? Eg. Cooking <ul style="list-style-type: none"> • What was it called? • How is it done? • Where is it done? • Using what (equipment/materials)? • With Whom & When? • Capacity, Knowledge, Skills required • Outcome of activity (e.g. end product) • Meanings & Standards 					

		<ul style="list-style-type: none"> Context: Sociocultural; Political; Economic; Historical Impact on Health Ref: Hocking (2013)					
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Enhancing Being Incorporates:	
F1:	Child centred
F2:	Authentic Relationship
F3:	Time & Space
F8:	Being
F9:	Occupational Alienation
F14:	Occupation
Please see Flower Attached Maria.Quinn@ntw.nhs.uk	

Please Tick (one only)	
	I agree a lot
	I agree a bit
	I can't decide/ I don't know
	I disagree a bit
	I disagree a lot

Top 5 Priority Areas from Feedback:

	Area of Concern	Action Planned	Results/Date Complete
1			
2			
3			
4			
5			

Date

Name






OT HCPC Registration Number:

Appendix 29: CROMS/CREMS: Enhancing Becoming

Questionnaire and Action Plan

A Toolkit for Occupational Therapy Outcomes:

Occupational Therapists Feedback

							
F1	1	Did the child show a commitment attend OT?					
F1	2	Was the child motivated to attend OT?					
F1	3	Did you have indicators which conveyed they were motivated to attend?					
F1	4	Have there been cancelled sessions on your part?					
F1	5	Have there been cancelled sessions on the part of the family/MDT/ward?					
F1	6	Did you create opportunities for CYP to achieve their goal for the session?					
F1	7	Did you make 'therapeutic work' feel like fun?					
F1	8	Have you evaluated the CYPs progress towards their own aims/goals?					
F1	9	Did OT intervention consider positive risk taking as an approach to skill acquisition for rehabilitation?					
F1	10	Were you aiming to increase independence and confidence?					
F1	11	Did you explain to parents/others the complexity of purpose behind an apparently fun activity?					
F1	12	Is the sense of selfhood internalised?					
F1	13	How do OT goals link with the internalisation of agency and self-hood?					
F4	14	Did you carry out an activity/occupation analysis prior to the OT session?					
F4	15	Did you grade the planned activity before the sessions?					
F4	16	Did you grade the activity during the sessions?					
F4	17	would you grade the activity in the future for this child					
F4	18	Did you grade the environment prior to the session?					
F4	19	Did you grade aspects of the environment during the session					

F4	20	Were there environmental constraints due to factors other than the needs of the child?					
F4	21	Did you maximise the grading of the activity/environment opportunities in the session, in order to facilitate them to meet their goals?					
F4	22	Did you have goals which the CYP were unaware of?					
F4	23	How did your goals impact on the grading of the activity or the environment?					
F5	24	<i>Have you been</i> an (informal) advocate for the child?					
F5	25	Have you facilitated Individualised Goal Setting and the development of an Internal Locus of control?					
F5	26	Have you assessed motivation and skills required to meet future goals?					
F5	27	Have you use of standardised assessments?					
F5	28	Have you recommended strategies to help parents and other agencies?					
F5	29	Does the MDT understand and value the role of OT?					
F5	30	OT looks relatively simple, have you shown people the clinical reasoning behind what is done?					
F5	31	Can you manage challenging behaviour and provide CYP with the feeling they are safe whilst in OT?					
F5	32	Do you demonstrate the expertise of facilitating the child as expert?					
F5	33	Have you called upon service user researcher to challenge current clinical practice, where CYP are disempowered?					
F5	34	Have you supported CYP to have having service user and carer forums?					
F5	35	Have you supported the CYP to take the initiative with their care plan?					
F5	36	Have you supported the CYP to manage key life transitional points?					
F5	37	Have you supported the CYP to establish routines and habits with life skills such as: <ul style="list-style-type: none"> • independent travel; • cooking skills; • getting fit; • opening a bank account • returning to school/ family environment • Becoming an expert in yourself • Building emotional resilience • a more fulfilling life. 					

F11	38	Have you identified areas of restrictions to access activities and done something about it?					
F11	39	Did you provide an opportunity for access to equipment, and positive risk taking otherwise precluded in other environments?					
F11	40	Have you identified and addressed gaps in the provision of opportunities for CYP to engage in meaningful activities?					
F11	41	Have you promoted positive Risk Taking & Increasing Access to Activities?					
F11	42	Have you encouraged CYP to assume responsibility for their lives?					
F14	43	Did you analyse the occupational form for its value in facilitating the child's BEcoming?					
F14	44	Did you specify which attributes of the occupation you focussed on to enhance Becoming? Eg. Cooking <ul style="list-style-type: none"> • What was it called? • How is it done? • Where is it done? • Using what (equipment/materials)? • With Whom & When? • Capacity, Knowledge, Skills required • Outcome of activity (e.g. end product) • Meanings & Standards • Context: Sociocultural; Political; Economic; Historical • Impact on Health Ref: Hocking (2013)					

Enhancing Becoming Incorporates:	
F1:	Child centred
F4:	Grading environment and activity
F5:	Goal Setting
F10:	Becoming
F11:	Occupational Deprivation
F14:	Occupation
Please see Flower Attached Maria.Quinn@ntw.nhs.uk	

Please Tick (one only)	
	I agree a lot
	I agree a bit
	I can't decide/ I don't know
	I disagree a bit
	I disagree a lot

Top 5 Priority Areas from Feedback:

	Area of Concern	Action Planned	Results/Date Complete
1			
2			
3			
4			
5			

Date

Name






OT HCPC Registration Number:

Appendix 30: CROMS/CREMS: Enhancing Belonging

Questionnaire and Action Plan

Toolkit for Occupational Therapy Outcomes:

Occupational Therapists Feedback






							
F1	1	Have you and the CYP got an agreement that you both attend every session?					
F1	2	Is there a therapeutic contract showing an agreement to attend each week?					
F1	3	Have there been cancelled sessions on your part?					
F1	4	Have there been cancelled sessions on the part of the CYP?					
F1	5	Were you consistent, empathic and caring?					
F1	6	Did you encourage transfer of learning from OT to other graded environments?					
F1	7	Did you explain to parents/others the complexity of purpose behind an apparently fun activity?					
F1	8	Did you encourage transfer of learning into ordinary and life and garner support from others, aiming for CYP to progress more swiftly?					
F2	9	Do you feel you have a trusting relationship with the child?					
F2	10	<i>Did you/OT</i> provide stability through transitions and change?					
F2	11	Have you managed to preserve a placement (school or home) and thereby extended periods of stability?					
F2	12	Have you noticed an emotional dependency from the CYP?					
F2	13	Have you noticed an am emotional link from yourself to the child?					
F2	14	Are you sometimes surprised by strong emotions expressed by CYP in OT?					
F2	15	Are you surprised by strong emotions expressed by CYP about you, in OT?					

F2	16	Are you surprised by strong emotions that you feel?					
F2	17	Have you found ways to manage the risks associated with establishing an authentic relationship with the CYP?					
F2	18	In supervision, have you discussed interpersonal dynamics between yourself and the CYP (and vice versa)?					
F2	19	Is your supervision sufficient to address your needs to maintain professional boundaries with the CYP?					
F2	20	Do you need more support?					
F2	21	Do you need a different kind to support?					
F2	22	Have you explored options for receiving different types of support and supervision to manage the complexities of establishing authentic relationships with CYP?					
F2	23	Do you receive monthly supervision?					
F2	24	Is you supervisor asking you about interpersonal issues CYP/yourself?					
F2		Do you need any CPD support to improve the effectiveness of how you utilise the authentic relationship you have built with the CYP?					
F2		Is developing your interpersonal skills and insight part of your appraisal?					
F2		Does the CYP need any support to manage the relationship which has been established?					
F2		Is the CYP asking intrusive/overly curious questions about your life situation?					
F2		Are you responding to intrusive questions from the CYP?					
F2		Are the MDT responding to intrusive questions from the CYP?					
F2		Is there a MDT approach to the management of intrusive questions, personalised to the needs of the CYP?					
F2		Is the CYP aware that the MDT is wanting to support them to understand the motivation for asking intrusive questions?					
F5		Have you been flexible in order to understand the young person as a whole?					
F5		Have you recommended strategies to help parents and other agencies?					
F5		Does the MDT value the role of OT?					
F5		Do others (MDT) understand the brilliance of what OT is doing?					
F5		OT looks relatively simple, have you shown people the clinical reasoning behind what is done?					

F5		Have you supported CYP to have having service user and carer forums?					
F12		Have you supported the CYP to establish routines and habits with life skills					
F12		Promoting family connectedness: did you bridge the gap of parent and child communications?					
F12		Have you been facilitating an internalised locus of control (sense of agency), whether on an individual or family basis?					
F12		Did children involve significant others (family, friends, MDT therapists and peers), to help achieve or recognise progress towards their goals?					
F12		Did they report back to tell you about what had been done and demonstrating a sense of connectedness?					
F13		Have you helped develop nursing staff to enable participation and counter occupational marginalisation, whatever time of the day children wish to engage in activities?					
F13		Have you enabled a more participatory environment by having activities available for young people to choice to engage in or not?					
F13		Have you sought to remove the gatekeeping role of any member of staff, in restricting participatory choices for CYP?					
F13		Have you supported service and facility design, to avoid structural causes of occupational marginalisation?					
F13		As with all occupational injustice categorisations, the duration of exposure to them is a factor in how much impact they have, along with many other factors, such a personal resilience. Have you calibrated the impact of any occupational injustices?					
F13		Occupational Marginalisation: have you identified any hidden in normative standards which dictate where, when and how people will or should participate?					
F13		Have you provided OT Outreaching Participative Options for CYP within Ward Rules?					
F13		Have you endeavouring to bridge occupationally marginalising practices and enhance participation?					
F13		Have you supported the transition from Ot to a more authority, rules led environment?					

F13		Is the pattern of OT provision occupationally marginalising?					
F13		Have you helped develop a sense of community and citizenship?					
F14		Have you supported the acquisition of time management and organisational skills for occupational roles?					
F14		Have you supported CYP to linking in/out OT sessions? the child as expert?					
F14		<p>Did you analyse the occupational form to enhance BELONGING?</p> <p>Eg. Cooking</p> <ul style="list-style-type: none"> • Eg. What was it called? • How is it done? • Where is it done? • Using what (equipment/materials)? • With Whom & When? • Capacity, Knowledge, Skills required • Outcome of activity (e.g. end product) • Meanings & Standards • Context: Sociocultural; Political; Economic; Historical • Impact on Health <p>Ref: Hocking (2013)</p>					
F15		Have you addressed issues of occupational injustice more broadly? (eg. Feedback on Policies, Practices, Challenging Practice beyond your caseloads, providing supervision to someone else).					

Enhancing Belonging Incorporates:	
F1:	Child centred
F2:	Authentic Relationship
F5:	Goal Setting
F12:	Belonging
F13:	Occupational Marginalisation
F14:	Occupation
Please see Flower Attached Maria.Quinn@ntw.nhs.uk	

Please Tick (one only)	
	I agree a lot
	I agree a bit
	I can't decide/ I don't know
	I disagree a bit
	I disagree a lot

Top 5 Priority Areas from Feedback:

	Area of Concern	Action Planned	Results/Date Complete
1			
2			
3			
4			
5			

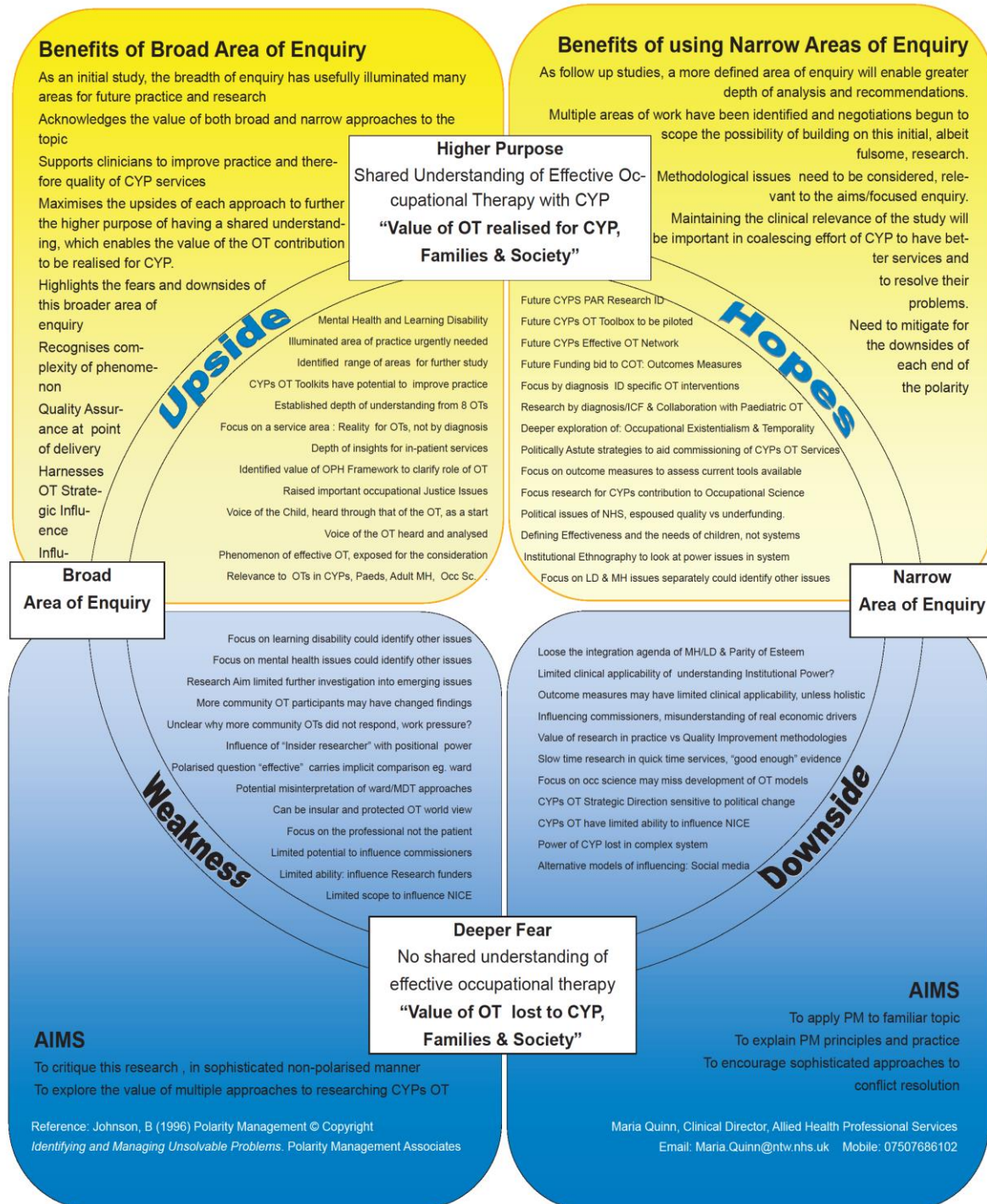
Date

Name

OT HCPC Registration Number:

Appendix 31: Polarity Management: Effective Occupational Therapy

Appendix 31: Effective Occupational Therapy



A Polarity Management Analysis of the Benefits of taking a Broad and Narrow Area of Enquiry

Appendix 32: Diane Interview 4

MQ Welcome and thank you for helping, its much appreciated.

Di No problem

MQ What I'm interested in looking at and understanding is trying to get to the essence, understand the core of what really might be making a difference in occupational therapy sessions with children. So, I am interested in what the experiences of occupational therapists are, so that's why I've asked you to be part of it. It is not trying to interpret it. It's just trying to describe some of these standout sessions in your career or ones that come to mind that you think, actually, I really think that made a difference and to describe them this much to detail as possible. That's it.

MQ So it's over to you. Have you got any sessions or children that come to mind when you say that?

Di ... I've worked with children for many years and I've worked with children in many ways. I guess in terms of the richness of my OT experience I probably have to draw on the more in-depth work that I've done with children over several years. At the moment I'm doing work that is a lot more based around developmental play therapy, which is still very important, but in terms of experiences that are important to me. I would probably go back to to working with children over longer periods of time and inpatient settings.

And there are children that I've worked with that I'll never forget, because of the quality of the experience that I had with them. I think what I would probably like to highlight first is the amount of time it can take to engage children who are extremely troubled and that I feel that that that isn't available as much now for therapists. And I would like to highlight that I feel that now my work is lacking quite considerably because I don't have the quality of time that I used to have to spend with children. And I think a lot of traditional research around play and how children use play and how children use the therapeutic relationship, has highlighted that, you know, it's a process that's should never be hurried and is a gradual process that takes time to evolve and it has to be very much at the child pace. Some children can engage very quickly in therapy and can actually use activities and the environment to gain a major emotional understanding quite quickly, but for other children, it's a slow process. It shouldn't be hurried along and can actually take substantial amount of time before you actually get to a point where you feel that that child has made a connection with you and the material that you're working with, and is able to gain some understanding of what's happening to them really.

So, I'm trying to think, do you want some examples of children?

MQ You know the ones that have a connection with you and a connection with the activity, that seems to be the ones where there is a moment where you feel like it's all coming together. Having set up that engagement, can you give an example, when you think that that happened or where it made a real difference to the child, that they started, that therapy was okay

Di okay, a little boy that I worked with, I can think of a few now they've started to come through. A little boy that I worked with who was an inpatient because he had really is severe problems with soiling. He was using sessions. I used to see him once a week and I felt for a

long time that his engagement with me was very superficial and that I was struggling to get any kind of relationship with him, and there he was coming in and having a nice time, he was feeling contained but it just felt very superficial. And then after probably 12 weeks of intervention to help him feel safe and secure, he started to use the doll's house to play out some family scenes, around domestic violence and police being involved. Although he wasn't identifying personally with the figures, I knew that this little boy had a father who had just been sent to prison for domestic abuse and there had been a lot of safeguarding issues and that he was afraid very frightened little boy. As a team, we did feel that the soiling was linked to the experiences that he had been through quite recently. He just started to use the figures to act out scenes of distress and violence and when he was doing that, I started to identify with the feelings that he was projecting into the activities. And I think it just enabled me to be able to knowledge with him some of the feelings behind the activities that that he was

MQ so what were you actually saying, you know you so you identifying, were you saying something, what were you doing and saying?

Di well he would act out where scenes where the figures were fighting and the little boy was on the roof, the little boy figure was on the roof, and the little boy jumped off the building and I just, you know talked about how, how worrying and frightening, I was feeling for that little boy in the roof... and how I wondered you know, what the little boy on the roof was feeling like, and I wondered who the little boy in the roof was talking to and he was able to open up a little bit about it. You know, he had quite negative views of the police and in his mind: the police had taken his dad away and sent him to prison and you know here, this boy heard the kind of stereotypical family stuff about you know is the police. They have taken your dad and you don't trust the police. We started to have a bit more of an open dialogue about actually some people that you may think are not here to help you, actually can help you and actually police can be really trustworthy and keep your safe. He started to then open up and do a lot more regressive play with the sand in the water.

MQ regressive did you say?

Di yes and then we were able to start talking about feelings about the soiling and feeling wet and dry and I think a lot of it, with all the children that I work with, is about establishing a degree of emotion, whatever issues they're going to bring they have to feel safe to bring them. It's about establishing emotional containment, so I guess even when I'm working with children on a shorter period of time and looking at developmental play and more functional skills, that child still has to feel safe and contained to perform at the base and be able to be able to use the activities and the environment to achieve, and to obtain the levels of emotional or physical independence. So even when you are assessing children if they don't feel like safe and secure you not going get...

MQ so what skills do you feel you're using in order to help them feel safe and secure?

Di I think communicating with children on their level is extremely important. So physically being at their level, but also emotionally at their level. So I always get to eye level when I'm engaging with them. I try not to to just take a child into an unfamiliar environment and assess them. But again, times are changing and you know you have to do that more and more, but then again it's about setting up the environment so that it's secure for the child. So you know

if you are going to do some assessment with them and ensure that they have adequate time to warm up first and have some transitional objects, that they find helpful.

MQ so you're talking about a secure environment and I think you're not talking about forensic, you're talking about an emotionally secure environment, (Di-yes)

I'm picturing a playroom ... with toys all around and its setup in a way that is in an Axlinian kind of way is that where you are at?, maybe you could describe it?

Di yes a range of developmental opportunities, so understanding that a child might be chronologically at the age of 15 but emotionally functioning as a three or four-year-old so that child has the permission to use materials that that they will find helpful so that you not imposing the 15-year-old should be interested in this, that and the other you are you have a range of activities on offer and I do think that even in changing clinical times you can still adapt any environment to make it as safe and supportive for a child as possible. So even when I'm going down to a clinical place and I'm only going to see the child for the first time and only 45 min I will still try and make my little space as welcoming and supportive as possible for the child. I'll remove things from the room that I feel are threatening and intimidating and I'll try and soften the environment and developmentally make it okay for the child.

MQ Can you say a little bit more about softening the environment is?

Di so I'll take out the medical equipment, I'll take out the pulse and blood pressure monitor the weighing scales and I'll cover things, screen things off. Again it's, unplugged the telephone. It's about having basic respect of children and sometimes it's easy for professionals to almost not see the child and see the system around the child. You know, communicate with their parents rather than the child, answer the telephone, if it rings in the middle of appointment with a child, it's about you know.

We use a lot of the work of Monica Lanyado who did a lot of work about creating a safe clinical therapeutic not just the children but for anybody who has intervention and a lot of the principles are very, they seem so straightforward and common sense, but actually when you look at modern clinical practice a lot of it does get lost in the kind of need to meet targets and get children through waiting lists

MQ yes. I'm interested in you talking about respect and it's making me wonder about any other values and things that are pivotal for you in terms of providing effective OT for children?

Di there

MQ you know values and attitudes

Di in respect. Attitudes and values?

MQ there may not be, I'm just wondering because you said that was, I wondered if there was any other ones?

Di the one that I always get personally I always struggle with and that I really feel is important is child confidentiality and working with risk when working with children.

And you know, I think a lot of you know, quite rightly, there's a lot of policy in place about safeguarding break usual that information is communicated to arrange a professionals about what happens with children but sometimes children have, sometimes children have voiced to me that they just don't feel able to engage in therapy because they just feels so scrutinised by everybody else around them and even quite young children have voiced that to me, in that it limits what they feel able to think about. And again as I think is OTs we are very adept at working with children using a variety of medium to help them express themselves in Safe ways and I have worked with children in nondirective ways in order to help them express their feelings without actually having to make a disclosure or says something that they feel is going to, that they are not ready to talk about. It but its difficult work and it leaves you with the need for quite intensive supervision

Di I am working with a young girl now who again who has has withdrawn consent for the information to be shared and has a legal right to do so but it's very challenging practice to kind of work through the mind field of that with the family and the child and it can be quite challenging. I do believe that tied in with basic respect comes a Childs need for a degree of confidentiality in order to be able to grow and develop, and get the most out of life, but obviously are clearly in line with safeguarding procedures.

MQ it sounds like there's what's the child needs and what the system needs and that there are times when what the child needs, in your view is that really safe space. Actually, what came to mind was like a confessional. You know that absolute confidentiality almost somewhere where they can say anything and there'll be no response, because that's just what they need

Di and it is so difficult because I've worked with quite a few children over years to have been extremely traumatised and extremely troubled and can't move forwards at all, and you know they need that space, you also know that if and they know that if they do really talk to you about what's happening for them, everything else around them falls apart and you can do, you know you can counsel then you can talk about that, but in that child's mind they are not ready to make that disclosure because of the implications that it would have on their whole system, and as a professional if they did, you knew you couldn't keep that confidential, you have to instigate safeguarding proceedings and it is essential.

And that said, at the beginning of any therapeutic chat which work with the jargon, no matter how what, how old they are, not even if they're very little. in some form, I talk to them about, you know what information is shared and the having to communicate that with other people, even with a very little ones I try and have some degree of understanding that I work with other people and I'm there to keep them safe

MQ it feels a bit like your, you know, you can see what the child needs and you are kind of having to navigate them through a system that may not meet what they need. (Di -Yeah) So it's making me wonder if the system should change?

Di - Yes

MQ and I suppose when you say is really important and you struggle with that, I'm guessing that if we could underwrite the risk of anything happening, that you could say you know this is for this child. We've done enough work that we know, actually probably know, that the example that you gave that the father is gone to prison that that's the

main thing. Probably the main thing is that there are situations where actually for the child the main thing is to talk... if we could underwrite that for you as a clinician or them as a child, that it would be a different. How different might that be do you think? I know we're in the realms of imagination.

Di I think for a few children, I managed for a few children, I spent many, many weeks battling with that.

MQ can you give us a particular example?

Di a young girl ... that I worked with, we were working together. The young girl was presenting with what we felt was a post-traumatic stress psychosis and (she) spent a lot of time asking very direct questions about exactly what information would be shared with other people and then she became really really cross with me because she felt that we had a good relationship, that I was the person that she wanted to help her through the difficult issues she was having, but just felt that she couldn't speak to me because I would tell the entire team about what She was about to say. and she would scream at me "you'd tell them if I had toast for breakfast" and even trying to clarify that you know what everything. Not everything has to be passed onto other people it would only be things about your safety, she knew that what she had to say to me was about her safety for that. And she also knew that what she had to say to me was about, would help her work through things.

And that girl actually ... wrote to me several months after she left the hospital and she said it had been very helpful time and that she had actually being able to work through feelings in a way that she hadn't realised that the time. And she thanked me for that and eventually there were to even though it been very difficult because we did a lot of artwork which was her way of expressing things non-directively,

but then, she then went on possibly 12 months later she had moved out of the area and we had a whole host of people come out from another service to discuss the case because she had submitted a very, very detailed piece of literacy to an English exam board , which basically described what I thought had happened to her at the time. And again it was still

MQ she wrote all down?

Di she wrote all down in her English exam

MQ wow

Di again, it sparked off a lot of alarm, but it's still not actually enough to instigate safeguarding proceedings so she did get it out in the end through her English exam but again, it made me feel really, really sad because I just felt that she was ready, she is still struggling to come to terms with something that she couldn't express anywhere safely.

MQ it's reminding me actually of another piece of work that I talked about with another OT, not as part of this project. This is several years ago where she was working in a school with really, with children that were really disruptive and parents that had tried to do parenting classes but wouldn't talk to anybody. And I remember at the time, in order for the OT to run the groups ... the service manager, underwrote the risk that because the parents in the group was so unguarded "I'd give them a good clobber" which if they said that in any other situation you would be on to social services but

(instead) said 'look, it's okay for you to hold that, and not report it and if at the end of the parenting, there is enough (evidence). They had a contract that underwrote that the OT didn't have to do that and those parents really engaged and they did really, really well, and it feels very similar somehow but I'd never put those two things together in my head until now. It feels like there's something that we could be doing that would help the children. Like you say you felt sad, it's a shame if they're in the most specialist services, inpatient services... and if they can't get their needs met there, then where can they get them met?

Di has to come out then English A-level paper it's really, really sad

MQ there's something to be learned from that isn't there? Are there any other examples for you where it feels like you were able or the OT did make a difference. You may think that the OT made a difference to that girl, although it was sad, although it evokes a sad feeling for you, but it made a difference

Di I think it did, because then we worked together and that again that's another quality of OT is that we can be extremely resourceful in how we use the environment and the activities and actually we did work in a way which felt safe. We managed to work on the feelings but actually we would have done better if we had were actually worked on the facts as well, I still feel that we managed to make some emotional progress.

Di I think working with children and young people with eating difficulties is an extremely important area where I feel that I have made some really good progress with such children and again. Time is important but children with eating difficulties have a tendency to have a lot of issues around control and feelings of stuckness, and internalise a lot of their thoughts and feelings other absolutely unable to talk or think about what's happening for them. There is a cognitive issue with children that are clinically underweight but I am talking about the children that are perhaps of a little bit more stable weight, who would use activities in OT use therapeutic work to think about the control and the stuckness. So I remember I often refer back to a young girl who I worked with who was 11 and has a diagnosis of anorexia, and for 12 weeks, twice a week. We played chess. At the time, initially, I found it extremely frustrating and I just felt that I couldn't make any inroads and that she wasn't engaged but with some quite good Supervision. We managed to work out that actually that chess is really a safe game and actually it's it goes a very slow pace and actually there's a lot of stalemates and there's a lot of times when you can't make a move and you can't move forwards and actually when I started to back to bring it back to the game and the stalemates and they're making your next move is wondering what the next moves might be, eventually we managed to move on from chess and it was again, with time.

We managed to get into the kitchen, but we wouldn't have been able to do that without that foundation, without the kind of getting to the child's level and helping her understand that I actually understood to be stuck because, I felt really stuck playing chess. Every week, twice a week for three months I was frustrated, irritated, I was everything and until I actually was able to use the activity to acknowledge that I wasn't able to open able to acknowledge how she was feeling, and when we managed to do that, I managed to move her on to thinking

about food and the controls and the stuckness around food and we managed to get into the kitchen and start thinking about baking and making things and working out, you know losing a little bit of that rigidity, and control. She did really well not just in OT but across the board.

Di I think with OT it's important to acknowledge the people around you that work with the children as well because I think this is not necessarily you that makes the sole difference you know there's a team of people all around you. So whilst you're working with the stuckness and the issues around food. Other people are coming in ways healthy weight management CBT strategies, which all come together and help the child but I think what OT has, that I think is really special, is the ability to kind of adapt almost by the moment to what a child is doing, so that they can succeed using the environment and the activities. I feel that, I had a lot of psychotherapy supervision around this time and at the time I was doing my psychotherapy, MA and had wondered whether or not I would like to go and complete the whole psychotherapy training and almost move away from the profession of OT and actually doing that work. It made me realise that actually I was in the right profession because, we are so creative as OT is we can actually use, very flexibly, whatever's around us the environment a whole range of activities grade it very, very specifically to for that child needs. where a psychotherapist just work entirely that psychotherapists work entirely with the psychotherapeutic relationship but I do feel that active by adding activities and using the environment more creatively with kids, it can sometimes dilutes the intensity of what you are doing but I think I think children need that, they need flexibility in and being able to be held, to come and go a little bit and test things out and withdrawal and sometimes it's just too intense to be sat in a room with somebody in a very limited range of resources and really thinking of the raw emotions. I think if you are in tune with that child. You can then dip in and out of very difficult issues as that child is ready and you'll find that they'll come back. Week after week after week, you don't lose them or if you do lose them and you only lose them for a very short period of time they will come back. We had a range of environments and again, sometimes just knowing that that child needed a larger space, they needed to be just that little bit further away from you and being able to just pick that up and know that that child can have that, I think is really useful.

MQ in all of that, I'm absolutely with you. It's reminded me of the unit where (I) had the gym and had quite a large space, a kitchen space. There was a small pottery room you know there are lots of different choices.

MQ I know you touched on this before; about how it's slightly different now and that might be limiting some of the therapeutic choices available. But I'm interested, because you mentioned that even now: if you're seeing a kid for 45 min, even just at a desk or at space, you're trying to emulate some of that. So the manipulation of the environment - is that really crucial and pivotal in terms of your decision to stay as an OT and the environmental aspects and the activity. As you were talking, I was thinking about you being at eye level. The other thing you are manipulating is yourself isn't it? So I don't know whether you think of that as separate to the environment and activity, it's another component that is varying, in order to keep this child in the force field of therapy

Di No, absolutely. You have to use yourself and you have to use yourself, because none of this will work, none of your therapeutic interventions will be successful, if you don't create the right personal engagement with the child.

Again because, I guess because I'm working with children, mainly with autism spectrum disorder. My use of self is different. My eye contact has to be more exaggerated. I have to exaggerate a lot of my social skills in order to get the best out of the children that I'm working with now, which took a while to master actually, because it was not how I was used to working.

MQ Can you describe that in a bit more detail, the difference? Because if you're unpicking how you might adapt yourself, you've had that experience of quite psychodynamic long-term in patient work to short-term (yeah), you know you've done the whole spectrum of clinical presentation

Di well, now, if I'm working with the child who is quite clearly on the autistic spectrum you use less words, not more words. They are quite likely to struggle with some of the more abstract language I would use with children at the other unit, the more subtle hinting about thoughts and feelings is not really very helpful to children with autistic spectrum disorder, you actually have to be very clear. You have to tell them if you are happy or if you are sad and hope that they, is that they can then start to model and link their feelings with what they are doing at the time. They are struggling to connect their emotions to their behaviours, so my role is a lot clearer. I have learned that if you use too many words, it is just over their head, you're just ignored. if you give children too many choices, they won't choose the option that you think they would choose, so you have to be much more directive and really quite clear and I found it really difficult sometimes.

Again, it's, I have also found that with some children regardless of diagnosis, that you still need to give them the opportunity to use the activities to express their feelings. They may not have the words, and they may be struggling to connect with your interpretation of what they are feeling because they don't feel or connect with the words or the behaviours. But actually, you can still use more physical modelling with the activities to help them to understand and make progress. So it feels more developmental, more structured, but I think the principles of engagement are still the same, you know, I would still try to develop consistency and a rapport and certainly be at their level and their developmental level. And you know I am finding that the children do form therapeutic relationships and actually they may not be able to articulate it in the same way, but they do expect to see me every week at the same time and actually they will struggle if rooms are changed, which happens frequently where I work now. I've got to see a little boy next week in a different room and I know that's going to be really challenging, so although it's different, is not, some of the principles are still the same I think.

MQ it's fascinating to hear and your drawing on such a lot of different things like developmental theory, psychodynamic theory, it almost feels like that you're able to bring a form of psychodynamic therapy to children with autism

Di I try. Yes

MQ yes but it is not psychotherapy it is occupational therapy informed by psychotherapy, is that about right?

Di and I think again that so inherent to what I've done that I can't, it can't disappear. I have to work within the remit of what I am doing at the moment because that is the service that I am employed to work in. I do believe in what I am doing, I'm looking at a lot more at the Childs

difficulties and putting the strategies in a child within the home and school and it's an important role, but I don't have as long to work with children as I used to do, I do still think it's important to gain an understanding of what else is happening for that child as well and you know often the cases that we get through our... autism service are not clear cases, these are cases where children have had some very difficult early experiences. Family relationships are strained, there are a multitude of other issues within families, and I think it's important to have that framework as well.

MQ do you think you have a particular, I have two questions...

I'm wondering if you have a particular function in the team. But I'm also thinking about, wondering about... your thoughts about how important it is that children, no matter what their diagnosis is, have got to have a way of expressing and connecting with emotions and the skills that you have, which allow that to be. And also, that is such a strong belief that it's spanning different services, no matter where you are, so there's something about your own belief system about how crucial that is for the children, that no matter what the environment or the diagnosis is, that that is the thread that carries through. Is that right, have I got that right?

Di yes within the team that I work in, I would say that there is a mixed response to that work. There are some key professionals that seek that and value that greatly and would see that as my key role within the team. But if I'm being brutally honest, I would say there are other professionals within the team that I work in that don't feel that that's important and feel that we are here to diagnose XYZ full stop, and I found are very challenging.

MQ Can you give us a really tangible example of where that's been an apparent issue?

Di Again, a young girl who I saw quite an early on in my new post with the xyz team, who reportedly couldn't play. And had, was seen by our team and was thought to have, the query over autism. And we observed in school and she was extremely isolated in school, very aggressive within the home environment and again I get into difficulties within our team because we do some very standardised play based assessments. According to how imaginative a child's play is within these are very structured standardised assessments, we grade that and match that with the developmental history which gives you an apparently over 95% of correctly diagnosing autism. But what I sometimes find is that when I'm with them, the children play very differently to how they play in a very standardised assessment. it's quite hard to get that across to the team and that actually if you do this, or you scaffold a little bit of play here, actually they do have those skills, but you know there are other things happening For that child. And I saw this little girl early on in my post, now I think might be a little bit more, I might have been a bit more stronger in knowing what I wanted to do with her but I was quite new into the post and I was trying to find my feet and this girl apparently couldn't plan and the team at had done a lot of assessment and would definitely feeling that she would fit an autism spectrum disorder. But a couple years ago on holiday there had been an incident where there had been a lot of alcohol abuse in the family and mum and dad, they were professionals, who had both experienced some alcohol difficulties and has sought help and have managed to overcome those difficulties and this little girl was still within the home. I don't think there had ever been any social services involvement as such, but there had been an incident on holiday where dad had drunk too much and collapsed and there had been abroad. It is all been very

unpleasant for this little girl. I only got to see her three times and I was really quite furious that I only got to see her three times up. I really felt we weren't giving this family enough time to get to grips with what was happening and this time they were very keen for a diagnosis of autism. I think they felt it but it very much underpinned their daughters difficulties. But in sessions with me. I only saw her three times. She was doing a lot of lining up which is quite stereotypical for children with autism but its also quite typical of children that have had a lot of chaos in the lives and a lot of disruption, to try and order play is quite important. Again, I made a few acknowledgements around that and very gentle comments about things needing to be safe and in order, and she quite quickly began to play with the figures and actually was doing a lot of emm re-enactments and again, you know, you could argue that children with autism re-enact rather than play

M yes

Di but what she was re-enacting just felt too... symbolic of what (laughing) she was...She was re-enacting situations at school and ..emm..

You know dolls and figures, about arguments within the home emm, and actually, I was able to play with her developmentally, I was able to extend her play and actually I felt that she had some really good imagination and symbolism, she was using objects for things that they weren't, which again is not typical of children with autism

MQ that is right...its very abstract isn't it.

Di and I didn't feel that this little girl would necessarily meet the criteria for diagnosis of autism. We had a lot of discussions in the team about the emm, the importance of not dismissing a child's early history and you know...

How would we ever know whether this child has an underlying neurodevelopmental vulnerability and the answer is you can't know there's no test, there is no blood test, that there is no brain scan that will show you whether this child has autism, it comes down to clinical judgement. And I find that really difficult and I guess you know a child can go to one service and get a diagnosis and then go to another where they wouldn't, because one professional feels it is one thing and one professional feels it's another. It does not matter, in my mind, it doesn't matter. It's about what that child needs, you know, in order to function, but I guess that was where I felt (I have gone off on a tangent, I think) that that is where I felt actually if you use a little bit of emotional work and psychodynamic understanding, you might get a different picture. and I see that all the time with this standardised assessments that we do, that they just, they just scrape the tip of the iceberg, I just feel that we don't see children at the best when your meeting them for the first time asking them to make of a story about over a series of things, it doesn't

MQ it's a tall order

Di it is!

MQ that whole thing, about the complexity of manipulating the environment, an activity, yourself and then the concept of a standardised assessment, just seems like it's at a really different place

Di Yeah, and again I'm still in a dilemma of whether as an OT to train to do this assessment because it's quite,

MQ What is it?

Di It is the ADOS assessment. It's quite crucial to the work that the team do, when I first came there was going to be a discussion.. oh yes I'll get trained to administer these assessments and then it was decided that now I wouldn't be doing that because... I actually was going to offer something different and I do feel that I do that and now it's coming full circle and people are thinking actually I should be trained. Maybe I should be able to see both sides and I guess without being trained in that assessment. It's hard, maybe I shouldn't be critical, so maybe I have to be trained in it to be kind of. Laughing...But then it might change me completely!

MQ what do think the likelihood of that is?

Di what of being trained or being changed?! Ha-ha

MQ Being changed completely! Because I suppose, what the other thing that's striking me, is you used the word furious that you could only offer that girl three sessions and I'm really struck by your passion.

DI ah hem, yeah

MQ Also, you mention supervision of number of times that you had, you know .. like the girl you're playing chess with that you had quite good Supervision and I feel that there is another component to keeping really good Occupational therapy on track, that is about supervision. So, I suppose I am wondering where you are at with that?

Di well, I guess I get... I do look for emotional connections with the people that I work with and I can't really see myself as an OT if I don't connect emotionally with the young person. The downside is that of that is that, emm you have to be fully aware of how you're connecting, and you know, in an ideal world yes you would be fully contained and you would be able to see where your influence is there.. emm,

But the reality is that quite often, you get over entangled with children or children's' families and you need somebody external to be able to say "hang on a minute. Why are you saying this and why are you feeling like that?"

You know some of the cases that I've done as part of the bipolar service; you know where you work emm, and again you know you connect with young people but you're not sure why...and you need to have some really good supervision to help. You know

It's usually in my case, it is to pull me out of cases because am wanting to work with them for too long. So normally...

MQ what is excellent supervision for you, in order to provide excellent occupational therapy for you. When it's really what you need it to be.

Di What is excellent supervision? You know the probably the best that I get is...emm... I mean I'm lucky because I've got, as you know my supervisor is somebody who I've worked with them many years, the who I trust implicitly with my cases, so that I can go and I can really

be honest about how I'm feeling, what I'm doing and I just feel safe to do that. I am really really lucky that I've got that because that is somebody that I've worked with for so long and I feel so safe with. So that's, that is, I feel that I know, in that respect, I have that.

But I also value the monthly psychodynamic OT supervision sessions at Xzy once a month.

Again, I get to take my cases from my current post that may be on the face of it, you would feel that there isn't a psychodynamic perspective and that they just feel so straightforward. And I just, I'm constantly amazed by what the psychotherapists can pull out from that and make me think about and then I can take back to the team, and taking some of those cases recently, it just kind it keeps me inspired by what I'm doing, and stops me feeling that I don't have the opportunity to think like that anymore. Sometimes in the daily grind of it, you can sometimes feel like you're missing out on what you're used to do and I can get that from some supervision and thinking about case.

MQ there's something about the consistency and about really safe and it (supervision) being inspiring and a fundamental kind of environment

Di yes

M there's a couple of things; are there any other examples, that you'd like? If you wish to, you can think of other things you would like to bring to this, emm.

At some stage I interested to know if you feel like there is a metaphor or a picture that might sum up , when OT is really effective, you know.. that's like what.. Does it illicit a thought or a picture or a metaphor for you?

Di I keep thinking of a rollercoaster, because that's how I feel about working with kids, is that when you actually connect with them and you can see the change, it's absolutely amazing. It's just, the best feeling ever, when you make that connection and you can see progress and development and you can see the children are kind of setting off down a path that is better for them, that they have chosen and they have had a part in. That's amazing. And that's the highlight but then

the low bit is kind of really quite horrific in managing the kind of dynamics around working with children and the emotional processes, the risks, the legal system and around kids. The fact that we are working in, it needs to be said, were working in times where people aren't investing in children's services and it makes me so cross, that when we have all the, you know, developmental research, the risk and resilience theory about interventions with children at a young early age and the prognosis for children for children if we intervene early with families,

you know , the research is there, risk and resilience theory, why aren't we investing in children? we pour money into adult mental health but it's too late. We actually should be pouring the money into children's services. Because actually if we get that right then we don't need it as much of the rest of it and it makes and that's the lows for me, having to compromise for what's right for kids when, actually, I'm in quite a protected service, when I hear my colleagues talk about life in the community, I still fail to understand how it's got to this. How we place so little value on child mental health.

MQ Yes

Di You know it's national it's in the press is not enough beds. There's not enough care, when actually you've got to invest in their children's services in order to shape the development of our future population. I don't understand why it's not happening, that's the low. It's kind of keep on going and not like jumping ship in joining the millions of people in the private sector, That are carving out little businesses overcharging for a little bit of sensory intervention, when actually, if you just put the money in and offered a holistic package of care for kids when they needed it most, that would help I think.

MQ Is there anything out about the rollercoasters you know when you think about that rollercoaster has it got any other things about it?

Di I think it's got something around it like a container, I think it's, you know, you have to ride the rollercoasters when you're working with children but you need to have you know you just come off the end: If you didn't have some kind of overarching structure around you, to keep you safe. So, think you know, again. I'm going back to early psychological theories but the "container contained" you know I think you need to use that model in supervision, in teams, and again, if that fails, then that's where you have serious, serious difficulties.

So I see it as a rollercoasters with a big kind of container around it which would kind of keep you safe while you're working.

MQ is there anything else about that container that you know has got a size and shape or a texture,

Di don't know

MQ it's a rollercoaster... you can see it easy through the container. If you saw the rollercoasters in the container would I see the rollercoasters or it

Di yes, you probably see the rollercoasters and I think you'd see, just like an aura of film you know something to keep everything in there, you know if you are not able to be contained in amongst to the highs and the lows, by all means celebrate the highs with the families and the kids, you know you can share the progress, but if you can't contain the lows, it's not helping anybody. Families need you to be their container so you need someone to contain you doing that work. I think we do have that, we do have that

MQ we tend think of success interventions as, I don't know, the highs where maybe when people achieve their goals of what they wanted to do, but you don't always think of the successful intervention as "containing the lows", you know, that actually, it was really, really difficult but what we did what we did was contain it, that was the success, you know.

MQ It makes me wonder about how people perceive what occupational therapy does, you know you said before that, you know you manipulate things moment to moment, I'm wondering what people see, what does the team understand what they see OT is doing

Di I don't think they do. I think, very much, again I hate to do this. I hate to go back to what I see as being a better way of working, because it actually had its difficulties, but I feel that, unless you are an OT, it's impossible to really understand fully what you doing. So I think OT is have a bit of a chip on their shoulder sometimes when they kind of expect people to see

the brilliance in what they're doing all the time, because actually what you're doing does look relatively simple so I am taking a child into a room and get in the Duplo out, and I have actually got the luxury of being with that child for half an hour and of course it is going to be a nice time with a child who do this, that and the other, and I think it's very hard to expect other professionals to fully see the skill in what you're doing there . I've always felt as OT is really have a responsibility not to have a chip on shoulder and that we should get out there and show people, you know, you're thinking, your clinical reasoning, and what you're doing but

Don't expect people to fully appreciate it, because they don't live it. Emm

Di and again, I guess there are levels. I don't think the team that I'm currently working in fully understand what I can offer to a child and I would be lying if I said that didn't really dishearten me sometimes, but at the same time, I've got a responsibility to work with the families that are on my current caseload and do absolutely the best I can for them and see that child may progress so, sometimes that's appreciated by people I work with people and sometimes it goes unnoticed, but again

I'm not in it to get to get you know, commended by the team, I'm in it for the families that I work with. Even when I worked in completely different settings, people completely misunderstood what OT did, There are a number in our profession who get really defensive and again tried to over-jargon What we do and use language that again feels alienates us further from people, and I really feel that we just need to be proud of what we do actually do and if we use simple language to describe that and people connect with it, then I think that's back better than actually using. I mean the model of human occupation is my kind of issue with some of the language we use. We know we can produce amazing reports about volition habituation performance but actually if people who read them don't really get it and engage with it then there really isn't any point. Some I reports are quite simple, but I feel that I'm writing for the families of the children I work with and I want them to have a meaningful piece of documentation that they can then take with them. That's you know, that they understand and maybe I do myself no favours, by then again at the X unit. We used to have this discussion about you know should reports contain all this psychobabble, then, the families don't understand it. But then if you don't give yourself that professional edge, you don't get the respect of the team, so it's quite a delicate balance.

MQ That's an interesting one isn't it. So do you feel, I suppose in trying to meet the child's needs or the family's needs more closely. We are not in the game of trying to get the respect of the team, that's the downside.

Di possibly yeah

MQ have you got another thought about that?

Di I just think that, I think, I don't know. I don't know. I think because of what, as occupational therapists what we do is, and again having a student at the moment has been really helpful in thinking about this. Seeing a third-year student who actually has the bones of the profession, she's got the nuts and bolts. But it's not unconscious. You really have to think about every step of every intervention. She's doing and her clinical reasoning is sound and I can see her muddling away through her thinking behind this what she's trying to achieve and applying the environment, and the activities and she's doing it today on my behalf while I'm

here. But what I don't do is consciously is that. I don't kind of, and having her makes me think more, yes, she's doing everything that I do but she's doing it in a kind of almost disjointed way.

It's not kind of flowing and I guess the more you work, the more it just flows and becomes an innate in what you do, so you can't then automatically expect other people to understand the depths of your thinking because they're not OT's, they've not been immersed in the philosophy and the thinking behind what you doing.

MQ and if it is not consciously, you know , you are in flow, it is not articulated. I'm just wondering because you mentioned about flow and it's not something that we've talked about previously. Is there ever a sense that when you are completely immersed in what you're doing and it's going well and you are in flow, that those are sessions that are all working, I am wondering if it's a component of when sessions are effective, when you know that's kind of

Di I'm usually conscious of when something is working

MQ what are you conscious of?

Di feeling that there is change happening, that I'm connected

MQ connected, what does connected look like?

Di I actually think the reverse of what you said might be true in that, sometimes when it feels like it just flows, there is a tendency to miss things. I mean, everyone has sessions where may be it just seems to go like that (clicks fingers) or, And maybe the child did get more from its, but I think, Unfortunately, or fortunately, I think you have to be... I don't think you can just flow, I think you have to be acutely aware of what you are doing, at all times. Yes, there are times when it just flows, and that's I don't know whether that's good or bad, but, I think in order, I think you have to be able to be really thinking about each interaction and what it's meaning and how that's changing things. Sometimes that's about feeling quite uncomfortable, or quite aware that something is happening and actually progress is being made and sometimes that's a good thing and sometimes it's a bad feeling

MQ progressing.. your body that you're feeling it. It's a feeling?

Di yes. to me, if the session just flowed or passed. Maybe I wasn't quite as in tune as I should've been maybe I was not. Because even when I'm doing my developmental play stuff, I am still trying to shape every interaction with a child, every bit of Duplo. What are they doing? I'm not just sitting mindlessly playing with the Duplo, I'm thinking what is that child doing and how they are using their skills, and what I can do to enhance their skills.

MQ it sounds like that for you, there is a kind of constant parallel process. It reminds of the idea of the "helicopter view" that whilst there is you and the child and an activity going on in an environment you fashion. There's another process going on about you consciously thinking about the interaction what's going on and that you experience as an emotion in your own body

Di yes, probably

MQ yes so you feel it's like a parallel process. is there anything else that you'd like to add?

DI: I really enjoyed it, that discussion I've got a lot out of it

MQ good. That's good. I think there's something that's come out of in each of the interviews where, most people have said that afterwards their surprise, and also it's a bit like in supervision, you tend to talk about problem cases and actually having a chance to talk about when it is really working, those cases where is really working, and is just a different emotional journey, I guess as well. And it is making me wonder if there's lessons to be learnt from it about supervision, honing in on the things that were doing right, or that are most effective and doing more of it, instead of looking for the problems.

DI and I guess in terms of formal supervision, it's quite a precious time. So for me, I do have availability to see my supervisor if need to, but it tends to be about an hour a month but I have formal supervision. So actually, there really isn't a lot of time to really think in-depth, you know you have to cover your managerial things, your training needs, I supervise someone, so I have to cover that, and actually I could talk for an hour about one case quite happily, and yet some of the straightforward cases never even get a mention because my supervisor trusts that I am on top of those. I mean, I do case management stuff, care coordination, risk assessments and all that stuff it's an hour a month. Which is why the psychodynamic sessions are really helpful, but again that's really struggling a group.

MQ is it run by a psychotherapist?

DI It's run by a psychotherapist who was an OT though. Because people can't get away, people can't justify attending things that are so crucial to protecting the skills in practice

MQ that's what really struck me that in all of your examples you mentioned supervision or your own raw emotions which you bring to supervision, and what you talk about in supervision, so it's a crucial part isn't it, is obviously worthy of reflection.

I really appreciate your time, we will finish there, is that all right?

Appendix 33: A Glossary of Specialist Language Terms

Detailed reference information is alongside the use of these terms, in text. Mainly they draw upon the Occupational Perspective of Health (OPH) and the work of Wilcock and Hocking, 2015 and WFOT (see Appendix 1 and Reference list for more details).

	Description
Becoming	<p>Wilcock explained Becoming as:</p> <p>“Development Transformation Become more knowledgeable or mature Realize aspirations Achieve potential Creation of communal or self image Foundations for organization of lives”.</p>
Being	<p>Wilcock explained Being as:</p> <p>“of the mind, inner person, essence, core spirit, personality. Essential nature of someone; substance. Mental/spiritual self. Ideas and plans formed, sense of made of how to do Reflective or restful Relaxation and sleep phases of occupation Alternates with action and toil.”</p>
Belonging	<p>Wilcock explained belonging as:</p> <p>“Affiliations to others/places/things Being a member, constituent, a part of something Allied, akin, attached to something Being in the right place, feeling right and fitting in”.</p> <p>Wilcock explained of belonging as:</p> <p>“being in the right place, feeling right and fitting in”</p>
Doing	<p>Wilcock explained Doing as:</p> <p>“Mental, physical, social, communal, restful, active, obligatory Self-chosen, paid or unpaid occupations Action, participate, make, execute, prepare, organise, undertake, sort out, fix, look after Exploits, deeds, accomplishments”</p>
Occupation	<p>‘Occupation encompasses all the things that people do, is part of their being and integral to their becoming whatever they have the potential to become. Occupation has a biological purpose in that</p>

	<p>it is the mechanism by which people throughout time, have acquired all they need to accomplish in order to be safe and feel good.'</p> <p>Wilcock 2001. p.10</p> <p>'In occupational therapy, occupations refer to the everyday activities that people do as individuals, in families and with communities to occupy time and bring meaning and purpose to life. Occupations include things people need to, want to and are expected to do'</p> <p>WFOT 2006, p 2</p>
Occupational science	<p>'is significant to occupational therapy because... It underpins effective occupational therapy practice by providing a rich understanding of occupation as both the therapeutic means and ultimate goal of occupational therapy.'</p> <p>WFOT 2012. p.1</p>
Occupational Imbalance	<p>Defined within the OPH as un-occupied, under occupied, over occupied or having and imbalance of meaningful activities.</p>
Occupational Alienation	<p>Defined within the OPH, the occupational injustice associated with being, is occupational alienation, which occurs when CYP experience a sense of disconnectedness, isolation, lacking identity, meaninglessness and limited self-expression.</p>
Occupational Deprivation,	<p>Defined within the OPH as prolonged preclusion from engagement, outside of the control of the person.</p>
Occupational Marginalisation	<p>Defined within the OPH as one of the more invisible occupational injustices, as it is often hidden in normative standards which dictate where, when and how people will or should participate.</p>
Occupational Existentialism	<p>The term occupational existentialism has been coined as a result of this research, to capture the sense of children coming into their occupational existence during the course of their occupational therapy. It attempts to capture the emergence of a sense of being or of self, which is occupationally-focussed. This notion surfaced from the findings, where the centrality of developing occupational being may be interpreted as the route by which the child starts to develop a sense of themselves (their self-hood) through the therapeutic relationship and the emergence of an internal locus of control, evidenced through occupational choices. The emerging identity and setting of meaningful goals could be interpreted as the resolution of a nihilistic crisis, where the primary function of OT is to enable meaning making for the child, through occupation (Quinn, 2016).</p>